

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

**221095**

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE A. ARAPIAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1985</b>			2b. HOUR <b>9:05 a</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 29, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>18 Helman Dr./21502</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene A. Arapian Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mitzi Unknown</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>270-10-8667</b>	
17. INFORMANT <b>Mrs. Kathleen P. Arapian - same as</b>			ADDRESS <b>above</b>								

18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory insufficiency  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Chronic Obstructive Lung Disease with  
DUE TO, OR AS A CONSEQUENCE OF  
(c) congestive heart failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Generalized arteriosclerosis

19a. DATE OF OPERATION <u>8-4-85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>7-11</u> <u>1985</u> to <u>8-4</u> <u>1985</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-4-85</u> to <u>8-4-85</u> , that (I) (we) last saw the deceased alive on <u>8-4-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. R. J. Barrera</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R. J. Barrera</b>				22e. ADDRESS <b>Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8/4/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithburg Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithburg, Wash. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John J. Hafer, Jr. LaVale, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 7 1985</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



228115

Ziegler Funeral Home

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

Hyndman, PA

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Michael Baker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 5, 1985</b>		2b. HOUR <b>4:15a M</b>		
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02/02/47</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany county, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>tire manuf.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Mt. Savage</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>P O Box 390/Barrelville/21545</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>John P. Baker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret R. Spurno</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>214521597</b>		17. INFORMANT <b>Melissa S. Baker, Box 390, Mt. Savage, MD</b>		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary failure + Death</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Shock secondary perforated ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>	
19a. DATE OF OPERATION <b>8/4/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated ulcer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8/4 85 to 8/5 85</b>		22a. I certify that (I) this hospital attended the deceased from <b>8/3/85</b> to <b>8/5 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Andrew Stasko</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Andrew Stasko, M.D.</b>		22d. ADDRESS <b>924 Seton Drive, Cumberland, MD 21502</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/8/85</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cooks Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RD, Hyndman, Somerset Cty, PA</b>		24. FUNERAL HOME <b>Harvey B. Ziegler, Hyndman, PA</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 08 1985</b>	
25. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		26. ADDRESS <b>15545</b>		27. DATE <b>8/8/85</b>		28. TIME <b>15545</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20% COTTON

4:15a

11/14/82

Albany County

August 2, 1982

Second Joint Meeting

RECEIVED

934 Western Drive, Cantonment, FL 33501

John Smith, M.D.

AND ON HIS BEHALF

John Smith, M.D.

John Smith, M.D.

Albany, NY

2201 12



242121

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA MAY BECK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 16, 1985</b>		2b. HOUR <b>10:15P.</b> M.
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 31 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY -----	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD.</b>	13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>135 NORTH MECHANIC STREET 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY HAMMANN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY RHEA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-18-2469</b>		17. INFORMANT ADDRESS <b>TARBETTSVILLE MD. 21804</b> <b>ALLEN BECK 4002 OLD FEDERAL HILL ROAD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septicemia, gram -ve.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>DR. KANJITHAN</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8/18/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. KANJITHAN</b>		22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>AUG 19 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>rest lawn memorial park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>LA VALE ALLEGANY MARYLAND</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>213-21-1885</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

181515

FOUR COTTON FIBER

CHIEFLY IN  
17000



256006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 &amp; 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

HUMBERT FUNER AL HOME				STATE OF MARYLAND		21250	
1- STATE BOX 37				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
REGISTRAR CONFLUENCE, PA 15424				CERTIFICATE OF DEATH			
REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH MARIE BENDER				2a. DATE OF DEATH MONTH DAY YEAR 08 28 85		2b. HOUR 8:45 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Garret Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF HUSBAND, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa. 13b. COUNTY Somerset 13c. CITY OR TOWN Fort Hill 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE R. D. 1 15540 99999			
14. FATHER'S NAME FIRST MIDDLE LAST No. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Deal				16. WAS DECEASED EVER IN U.S. ARMED SERVICES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No. 207322803			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral as 76 cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of base marrow &amp; peripheral vascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-6-1985</u> to <u>8-28-1985</u> , that (I) (we) lost saw the deceased alive on <u>8-27-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>John Mehan</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-28-85	
22d. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 31, 85		23c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Addison Somerset Pa.	
24. FUNERAL DIRECTOR <u>Humbert Funeral Home</u> Humbert Funeral Home				25a. RECEIVED BY REGISTRAR SEP 6 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

900025

ALLEGANY COUNTY

1. 6. 4

111-5001

John C. H. Wu

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240063

1. FOR  
STATE  
REGISTRAR

**Hafer Funeral Home** STATE OF MARYLAND  
**1302 National Hwy** DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**Lavale, MD 21502** **CERTIFICATE OF DEATH**

REG. NO.

21251

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Diana Marie Bittinger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 22, 1985</b>		2b. HOUR <b>11:10p M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 7 - 1940</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>Ellerslie</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Ash</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Shafer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress Manuf.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215369189</b>		17. INFORMANT ADDRESS <b>Melvin Bittinger--same as above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>widespread Metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7-28</b> , 19 <b>85</b> , to <b>8-22</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>8-22</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John Mehanna, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8-23-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>909-B Seton Drive, Cumberland, MD 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>8-26-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn</b>		
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>		24b. ADDRESS <b>1302 National Highway Lavale, Md. 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1985</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Hafer, Jr.</b>						

1002 National Hwy  
Laval, MD 21502

210063

Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Albany County

State of New York

Box 124, Laval, MD 21502

Box 124, Laval, MD 21502

Enclosure

200-2 Laval Drive, Laval, MD 21502

John L. Laval, M.D.

Box 124, Laval, MD 21502

Laval, MD 21502

ENCLOSURE

256027

FOR SCARPELLI FUNERAL HOME  
STATE OF MARYLAND  
1- STATE REGISTRAR 108 VIRGINIA AVENUE  
CUMBERLAND, MD. 21502 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LEO CLIFTON BOYD			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 31, 1985			2b. HOUR 8:55 AM				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18 South Chase St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Boyd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva Spoon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 710 05 6169		17 INFORMANT ADDRESS Mrs. Margaret Boyd, Cumberland, Md. Wife					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypocalcemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Epilepsy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-29-85</u> to <u>8-31-85</u> , that (I) (we) last saw the deceased alive on <u>8-30-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John Mehan</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-31-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MEHANNA					22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502					25a. DATE REC'D. BY REGISTRAR SEP 06 1985			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential parts. Part 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



288027

STANBELL RURAL HOME  
100 VIRGINIA AVENUE  
CUMBERLAND, MD. 21502

LEO CLIFTON 8370 STREET 31, 1902 5:22 A

ALLIANCE

SACRED HEART HOSPITAL

210 02 6188

DR. JOHN KERNAN 800-E SEITE DRIVE CUMBERLAND, MD. 21502

232052

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21253

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
William Nathaway Boyd Jr.								X		8/		11/		19 85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	3 27 1913		72		MONTHS		DAYS		8/		11/		19 85		P 2:31	
7. BIRTHPLACE (STATE OR TERRITORY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Westfield, N.J.		U.S.A.		X		WIDOWED		Allegany County, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Memorial Hospital		Western Electric													
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS											
Maryland		Carroll		Westminster		YES		NO		847 Johann Drive						21157	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William Nathaway Boyd Sr.		Doris Robson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT													
No		136-12-4539		Helen M. Boyd												Westminster, Md. 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple Injuries																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES X NO					
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
				2:09 M. 8/ 11/ 19 85				subject driver in auto/auto collision									
21d. INJURY OCCURRED WHILE AT WORK X NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				roadway				Rt. #40 East of Cumberland at Rocky Gap St. Pk. entrance, Cumberland, Allegany									
22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident X, Suicide, Homicide, Undetermined manner.																	
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																	
ACTUAL SIGNATURE				DATE SIGNED								8/12/85					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Gregory R. Kauffman, M.D.				111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				8-15-85				Westminster Cemetery				Westminster Carroll Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Thomas D. Fletcher & Son				AUG 15 1985				Jona Davidson-Randall									
254 East Main Street				Westminster, Md. 21157													

MEDICAL CERTIFICATION

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228135

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21254

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Rose

Katherine

Boyer

2a. DATE KNOWN  
OF ESTI-  
DEATH MATED ☒ MONTH DAY YEAR

8

10

19

85

2b. HOUR  
11:30 P

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE  
PRONOUNCED  
DEAD

8

10

19

85

2d. HOUR  
4:30 P

Female

White

1

1

1917

68

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

10. CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK)

FOR MOST OF WORKING LIFE)

---

12b. KIND OF BUSINESS

OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Allegany

13c. CITY OR TOWN

Cumberland

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS

Maryland 21502

Rt. 9 Box 418 Cumberland,

14. FATHER'S NAME

MIDDLE

LAST

George

F.

Hansrote

15. MOTHER'S MAIDEN NAME

Malinda

MIDDLE

LAST

E.

Leasure

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

217-10-6201

17. INFORMANT

ADDRESS

Rt. 9 Box-416

Lloyd Boyer Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING

OR

CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE

AT WORK ☐

NOT WHILE

AT WORK ☐

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL  
SIGNATURE

Francisco Reyes

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

8-11-85

EXAMINER'S NAME  
(TYPE OR PRINT)

Francisco Reyes

ADDRESS

900 Seton Dr. Cumberland Mt. 21502

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

8/11/85

23c. NAME OF CEMETERY OR CREMATORY

Davis Mem. Cemetery

23d. LOCATION  
CITY OR TOWN

Cumberland Allegany Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Cumberland Md. 21502

25a. DATE REC'D. BY REGISTRAR

AUG 14 1985

25b. REGISTRAR'S SIGNATURE

J. W. Davidson-Randall

Leasure-Stein F. Home 230 Baltimore Av.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

50120



Aug 14 1951

228073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be filed as by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eugene Brant</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 3, 1985</b>				2b. HOUR <b>1:30a M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-30-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ret. glass blower</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>glass co.</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13e. STREET ADDRESS / ZIP CODE <b>634 Shriver Avenue/21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harvey Dawson Brant</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Leidinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214056505</b>		17. INFORMANT ADDRESS <b>Mrs. Gladys M. Brant, Cumberland, MD - wife</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive Heart Failure, Chronic Lung disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 28, 1985</b> to <b>Aug 3, 1985</b> , that (I) (we) last saw the deceased alive on <b>Aug 2, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul J. Livengood MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>8-4-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Livengood, M.D.</b>				22e. ADDRESS <b>BMG, 912 Seton Drive, Cumberland MD 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>08-05-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>					
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 09 1985</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP

228073

Baroness's Hospital  
108 Virginia Ave  
Oxford, N. York

August 3, 1952

Friend

Friend

Baroness's Hospital

Baroness's Hospital

21402608



Baroness's Hospital, 108 Virginia Ave, Oxford, N. York

Baroness's Hospital, N. York

Baroness's Hospital, N. York



253017

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALVIN EDWARD BROADWATER			2a. DATE OF DEATH MONTH DAY YEAR August 27, 1985			2b. HOUR 4:06AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Timberman		12b. KIND OF BUSINESS OR INDUSTRY Lumber		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 203 Upper Consol Rd. 21532	
14. FATHER'S NAME FIRST MIDDLE LAST James Albert Broadwater				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Platter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS 203 Upper Consol Rd. Margaret G. Broadwater, Frostburg, MD 21532					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Resistant Hypotension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Sepsis, 9-v.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic renal failure, upper GI bleed, Hx fractured rib</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. N. Ranjithan</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan				22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 8-29-85		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Avalton, Garrett, MD			
24. FUNERAL DIRECTOR <u>D. Lynn Puma</u>				ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

229017

20% COTTON FIBRE

100% COTTON FIBRE

DOWN

227121

FOR NEWMAN FUNERAL HOME  
1- STATE REGISTRAR PO BOX 267 GRANTSVILLE, MD. CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE THELMA LAST BROADWATER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 4, 1985		2b. HOUR 10:35A <sub>M</sub>								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 - 06 - 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.							
13. CITY OR TOWN OF DEATH Cumberland		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		16. KIND OF BUSINESS OR INDUSTRY Own home					
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland 17b. COUNTY Garrett 17c. CITY OR TOWN Lonaconing		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS / ZIP CODE Route 1, Box 71 ; 21539									
20. FATHER'S NAME FIRST John MIDDLE Olen LAST Wilhelm		21. MOTHER'S MAIDEN NAME FIRST Ada MIDDLE Elizabeth LAST Garlitz		22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				23. SOCIAL SECURITY NO. 217669765		24. INFORMANT Henry Broadwater		25. ADDRESS Route 1, Box 71 Lonaconing, MD 21539	
26. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal wide spread Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED				28a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
30a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		30b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		30c. LOCATION STREET CITY OR TOWN COUNTY STATE									
31. I certify that (this hospital) attended the deceased from <u>7/19</u> , 19 <u>85</u> , to <u>8/4</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>8/4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
32a. SIGNATURE <u>Wally S. Hijab, M.D.</u>				32b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				32c. DATE SIGNED 8/14/85					
33a. PHYSICIAN'S NAME (TYPE OR PRINT) WALLY S. HIJAB, M.D.				33b. ADDRESS 909A SETON DRIVE CUMBERLAND, MD. 21502									
34a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		34b. DATE Aug. 7, 1985		34c. NAME OF CEMETERY OR CREMATORY Blocher Cemetery		34d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Garrett, MD							
35. FUNERAL DIRECTOR <u>Neuman</u>				35b. ADDRESS Grantsville, MD				36. DATE REC'D. BY REGISTRAR AUG 12 1985				37. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100-100000

NEWMAN FUNERAL HOME  
PO BOX 303 CANTONVILLE, TN

MARY J. BROWN  
JULIA A. BROWN  
AUGUST 1, 1902  
10-300

1



ALLEGANY COUNTY

STATE OF NEW YORK

210000000

Transferred to the office of the  
County Clerk of Allegany County

WALLY S. HIGGINS, JR.  
2024 BETTIN DRIVE CUMBERLAND, MD 21502  
210000000 x 210000000

227111

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert H Butler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8/03/85</b>		2b. HOUR <b>2:10a</b> M		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/02 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany Co</b> MD.	
10. CITY OR TOWN OF DEATH <b>Frostburg, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Community Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Miner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Melvin A. Butler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arminta C. Durst</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215 05 7182</b>	
17. INFORMANT ADDRESS <b>Route 2, Box 592 Frostburg, MD 21532</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DEHYDRATION CHRONIC INTERSTITIAL LUNG DISEASE, ARTERIOSCLEROTIC VASCULAR DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 2</b> 19 <b>85</b> to <b>Aug 3</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Aug 2</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Chang</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. S. Chang</b>		22e. ADDRESS <b>HEcks Plaza, Frostburg, Md 21532</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-6-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>K Grantsville Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Grantsville, Garrett, MD</b>
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24. FUNERAL DIRECTOR <b>D. L. Newman</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1985</b>	25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

11111111



246050

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM #18. 3-BETAIN-PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (S))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21259

REG. NO.

1- FOR STATE REGISTRAR										21259									
1. DECEASED NAME (TYPE OR PRINT) <b>Harriet C. Casteel</b>										2a. DATE KNOWN OF DEATH MONTH <b>8</b> DAY <b>19</b> YEAR <b>85</b> 19 2b. HOUR <b>820p</b> M									
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>July</b> DAY <b>29</b> YEAR <b>1919</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>19</b> YEAR <b>85</b> 19 2d. HOUR <b>820p</b> M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE <b>Md</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Rawlings</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 3 Box 96 21557</b>											
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b></b> LAST <b>Callis</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Harriet</b> MIDDLE <b>Jane</b> LAST <b>Bowman</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>Rt 3</b> <b>Donald F. Casteel Rawlings, MD 21557</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8199</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Multi-system trauma</b> (b) <b>Motor vehicle accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Motor vehicle accident</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION <b>8-18-85</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Laceration of diaphragm</b>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>420 P.M. 8 18 85</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Motor vehicle accident</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET <b>Route 135</b> CITY OR TOWN <b>McCoole</b> COUNTY <b>Allegany</b> STATE <b>Maryland</b>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER				DATE SIGNED <b>8-20-85</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D</b>				ADDRESS <b>900 Seton Drive; Cumberland, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-24-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				23d. LOCATION CITY OR TOWN <b>Cumberland</b> COUNTY <b>Allegany</b> STATE <b>MD</b>									
24. FUNERAL DIRECTOR NAME <b>A. Craig Rotruck</b>				ADDRESS <b>85 South Main Street</b>				DATE REC'D. BY REGISTRAR <b>8/26/85</b>				25. REGISTRAR'S SIGNATURE <b>John R. Riddle</b>							





221096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8-5 21260			
1- FOR STATE REGISTRAR 1302 NATIONAL HWY LAVALE, MD				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST CARL FREDERICK CECIL				MONTH DAY YEAR AUGUST 4, 1985			
3. SEX				2b. HOUR			
Male				10:00A <sub>M</sub>			
4. RACE				5. DATE OF BIRTH			
White				MONTH DAY YEAR Aug 19, 1920			
6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR			
64 YRS				MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
				ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Labor Pool				Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Allegany Cresaptown				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13d. STREET ADDRESS / ZIP CODE				13e. STREET ADDRESS / ZIP CODE			
				13611 S.W. Cecil Ave/21502			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST John William Cecil				FIRST MIDDLE LAST Susie M. McKenzie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
Yes WW II				214162127			
17. INFORMANT				ADDRESS			
Mrs. Dora Cecil - same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cyanide</u>				2 years			
DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Septicemia</u> <u>myocardial infarction</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				21g. LOCATION			
STREET CITY OR TOWN COUNTY STATE				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> 19 <u>85</u> to <u>8/4</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
<u>Renato Espina, MD</u>				<u>8/5/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
RENATO ESPINA, MD				907 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				8/7/85			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Hillcrest Burial				Cumberland, Allegany, MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME John J. Hafer, Jr. ADDRESS LaVale, MD				25b. REGISTRAR'S SIGNATURE			
				<u>AUG 7 1985</u> <u>Randall</u>			



246027

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John F Chick			2a. DATE OF DEATH MONTH DAY YEAR 8/17/85		2b. HOUR 7:10a <sub>M</sub>
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08 24 30		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.	
10. CITY OR TOWN OF DEATH Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister	12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. STATE Md		13b. COUNTY Allegany	13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE PO Box 162, 21521
14. FATHER'S NAME FIRST MIDDLE LAST Theron A. Chick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fern Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 447-24-9065		17. INFORMANT ADDRESS Alida W. Chick, Same as 13e	
18. CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jeane H. Tan S.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/17/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Tan		22e. ADDRESS 48 Tarn Terrace, Frostburg, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 20, 1985	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Barton, Allegany, Md.	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR AUG 23 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson</u>	

52035

A. M. G. W. J. J.

220026

LEASURE-STEIN FUNERAL HOME  
230 BALTIMORE AVENUE  
CUMBERLAND, MD 21502  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21262

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
STANLEY LEO DONAHOE

2a. DATE OF DEATH MONTH DAY YEAR  
AUGUST 3, 1985

2b. HOUR  
5:45P M

3. SEX  
Female

4. RACE  
White

5. DATE OF BIRTH MONTH DAY YEAR  
Jan. 24, 1898

6. AGE (IN YEARS LAST BIRTHDAY) YRS.  
87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
ALLEGANY COUNTY, MD.

10. CITY OR TOWN OF DEATH  
Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY  
Allegany

13c. CITY OR TOWN  
Cumberland

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE  
Rt. 5 Box 382 21502

14. FATHER'S NAME FIRST MIDDLE LAST  
Peter L. Donahoe

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Mary V. Fisher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES ☐ NO ☐ (IF YES, GIVE WAR OR DATES)  
Yes WW1

16b. SOCIAL SECURITY NO.  
216-22-6244

17. INFORMANT ADDRESS  
Angela Hast, daughter 706 Holland St. Cumberland, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST  
DUE TO, OR AS A CONSEQUENCE OF, (b) C.O.P.D with Interstitial Fibrosis,  
DUE TO, OR AS A CONSEQUENCE OF (c) Right Hilax mass, metastatic bore disease, blindness

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
45 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

NONE

19a. DATE OF OPERATION  
NA

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
NA

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. NA 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
NA

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
NA

21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
NA

22a. I certify that (I) (this hospital) attended the deceased from 7/27 19 85, to 8/31 19 85, that (I) (we) last saw the deceased alive on 8/31 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Arvind Pathak DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
8/4/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
ARVIND PATHAK, M.D.

22e. ADDRESS  
913 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
8/6/85

23c. NAME OF CEMETERY OR CREMATORY  
Sunset Memorial Park

23d. LOCATION CITY OR TOWN COUNTY STATE  
Cumberland Alleg. MD

24. FUNERAL DIRECTOR NAME  
Leasure-Stein Funeral Home, Inc.

25a. DATE REC'D. BY REGISTRAR  
AUG 6 1985

25b. REGISTRAR'S SIGNATURE  
Davidson

230 Baltimore Ave. Cumberland, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

250032

A

FOR COTTON FIBRE

LEASER-STEIN FURNACE HOME  
210 BALTIMORE AVENUE  
CHAMBERLAND, MD 21032

STANLEY LEE DONAHUE  
AUGUST 7, 1992 2:14 PM

SACRED HEART HOSPITAL

ALLEGANY COUNTY

010-22-0010

AWARD PATENT, N.Y. 210-22-0010



07/84  
25M

DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 5 (SEE PAGES 1, 2, AND 3) TO THE FUNERAL DIRECTOR WITHIN 24 HOURS OF DEATH. THE MEDICAL EXAMINER SHOULD SIGN AND DATE THE CERTIFICATE, AND SIGNATURE SHOULD BE FILED WITH THE FORM PM-3, BEHIND PAGE 5, FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21253					
1- FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR				
Juanita Pearl Drew									8 11 85		0700				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		Cau		10-20-42		42		MONTHS		DAYS		8 11 85		0820	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			U.S.A.						Allegany						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frostburg			Box 106 Shaft- Frostburg Md					Homemaker			Own Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland			Allegany		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 106 RFD 1 Shaft, Frostburg						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME										
Marshall Neilson					Sarah Wellings										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS									
No			213-40-3879			Edward David Drew, Same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Obesity; chronic lung disease due to asthma															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			EXAMINER'S NAME			TITLE (SPECIFY)			DATE						
			Paul Snow, M.D.			Dpty			8-11-85						
			ADDRESS			Memorial H0spital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			Aug. 13 '85		Frostburg Mem. Park			Frostburg, Allegany, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Durst Funeral Home, Frostburg, Md.						AUG 14 1985									

AUG 10 1966 - J. W. Anderson-Randall

33-075

33-075

33-075

228101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 1- FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE OSCAR DREYER</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>XX</b> <b>8-2-85</b>		2b. HOUR <b>1:30</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>7</b> YEAR <b>94</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>90</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND CUMBERLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>MT. SAVAGE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CALLA HILL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLOTHING STORE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>MT. SAVAGE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>CALLA HILL 21545</b>
14. FATHER'S NAME FIRST <b>GOERGE</b> MIDDLE <b>HENRY</b> LAST <b>DREYER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N.A.</b>		17. INFORMANT <b>MRS. DONNA HUNT, CALLA HILL, MT. PRESS SAVAGE, MD 21545</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>		TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER DATE SIGNED <b>8-2-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b>		ADDRESS <b>900 Seton Drive, Cumberland, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/4/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEM</b>	
23d. LOCATION CITY OR TOWN <b>CUMBERLAND</b>		COUNTY <b>ALLEGANY</b>		STATE <b>MD</b>	
24. FUNERAL DIRECTOR <b>M. Sowers</b>		ADDRESS <b>60 W. MAIN ST. FROSTBURG</b>		25. DATE REG. BY REGISTRAR <b>AUG 08 1985</b>	
26. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-01-00 BY 60322 UCBAW/STP

TO: MR. JAMES H. HARRIS, JR.  
FROM: MR. JAMES H. HARRIS, JR.  
SUBJECT: [illegible]

RE: [illegible]

DATE: 08-01-00

BY: 60322 UCBAW/STP



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-01-00 BY 60322 UCBAW/STP

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-01-00 BY 60322 UCBAW/STP

TO: MR. JAMES H. HARRIS, JR.  
FROM: MR. JAMES H. HARRIS, JR.  
SUBJECT: [illegible]

RE: [illegible]

DATE: 08-01-00

BY: 60322 UCBAW/STP

225025

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MODESSA MAE EICHELBERGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1985</b>		2b. HOUR 4:30 p. M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 4, 1985</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital &amp; Medical Center</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raleigh S. Bender</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Lee Grove</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-16-1762</b>		17. INFORMANT ADDRESS <b>Donna A. DeLauney</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Depress

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Suspect renal source

DUE TO, OR AS A CONSEQUENCE OF

(c) abruptio cordis ? et alAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>H. Merrick</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. C. Merrick</b>				22e. ADDRESS <b>Memorial Hospital Medical Building Cumberland, MD 21502</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 7, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Major M. Osborne P.O. Box# 348 Williamsport, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1985</b>		25b. REGISTRAR'S SIGNATURE	

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1

COPIES OF THE



248027

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH A. EICHHORN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 24, 1985</b>		2b. HOUR <b>1:20P</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 2, 1902</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS MONTHS DAYS		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS P. MELVIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE CAMPBELL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-24-1237</b>		17. INFORMANT ADDRESS <b>126 MT. PLEASANT ST.</b> <b>FREDRIC M. EICHHORN, FROSTBURG, MD. 21532</b>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA - multi + multiple</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN STREET COUNTY STATE <b>Aug 18 85</b> <b>Aug 24 85</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 24 85</b> to <b>Aug 24 85</b> , that (I) (we) lost saw the deceased alive above (we) (did) (did not) view the body after death.						
22b. SIGNATURE OF PHYSICIAN <b>Dr. Williams</b>				22c. DATE SIGNED <b>8-26-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Terry Williams</b>				22e. LOCATION CITY OR TOWN COUNTY STATE <b>Memorial Hospital Medical Building</b> <b>Cumberland, Maryland 21502</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG. 26, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS CEMETERY</b>		
24. FUNERAL DIRECTOR <b>DURST FUNERAL HOME, FROSTBURG, MD. 21532</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



2120215

A.

83

JANUARY 2, 1906

WHITE

WHITE

ALLIANCE

XX

U.S.A.

REYLAND

ONE PAGE

RECEIVED

250 E. MAIN ST., ST. LOUIS

1

RECEIVED

ALLIANCE

REYLAND

CAMPBELL

WHITE

REYLAND

Y.

THOMAS

NO

102 MT. PLEASANT ST.

THOMAS M. RICHMOND, ST. LOUIS, MO. 61535



RECEIVED  
JAN 2 1906  
ST. LOUIS



RECEIVED

CAMPBELL, ALLIANCE, MO.

AUG. 22, 1905 ST. LOUIS CEMETERY

BURIAL

DRUG FURNACE, ST. LOUIS, MO. 61535

228116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21267

REG. NO.

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE KNOWN OF DEATH		22. DATE KNOWN OF DEATH		23. DATE KNOWN OF DEATH		24. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. DATE KNOWN OF DEATH		4. DATE KNOWN OF DEATH		5. DATE KNOWN OF DEATH		6. DATE KNOWN OF DEATH	
Goldie Corinne Eisenhuth		8 4 1985		8 4 1985		8 4 1985		8 4 1985		8 4 1985	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
Female	Cau	1 3 05	80 YRS.			8 4 1985				0800	
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	16. CITIZEN OF WHAT COUNTRY?	17. MARRIED	18. NEVER MARRIED	19. WIDOWED	20. DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA					Allegany MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY							
Cumberland	31 Boone Street	cabinet maker		Mfg.							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland		Allegany		Cumberland		YES		31 Boone Street		21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS	
William James McGee		Minnie Virginia (nmn)		no		215-07-4324		Mr. William Robertson, Cumberland, MD-son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I DEATH WAS CAUSED BY:		20. IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF		22. (b)		23. DUE TO, OR AS A CONSEQUENCE OF	
				Cardiac arrest				Cardiac failure			
								Coronary artery heart disease			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES		NO					
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		CITY OR TOWN		COUNTY		STATE			
22. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion			
death resulted from		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		8-4-85	
EXAMINER'S NAME		Paul Snow, M.D.		ADDRESS		Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
(SPECIFY)		08-07-1985		Sunset Memorial Park		Cumberland		Allegany		MD	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502						AUG 08 1985					

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246076

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM NMI FARRADY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 21, 1985</b>		2b. HOUR <b>00:45A<sub>M</sub></b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 13 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fabric</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Farrady</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lily Meyers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>214-07-3055</b>		17. INFORMANT ADDRESS <b>Ms. Sally Hansel 6611 Moly Dr. Falls Church, Va.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the prostate</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-21-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SUSAN SCHWARTZ, M.D.</b>		22e. ADDRESS <b>FROSTBURG PLAZA, FROSTBURG, MD. 21532</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/21/85</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1985</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the hospital or attending physician. The low requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

218070

00-124

NOV 21, 1982

THURSDAY

AT

WILLIAM

WESTERN COUNTY

BRIDGE ROAD HOSPITAL

214-07-3022



DR. GUYTON B. BROWN, JR. • WESTERN COUNTY, VIRGINIA, 22175

241011

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21269

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		21. HOUR	
ETHYL		VALERIE		FOCER				8		16		19		85		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
FEMALE		CAUC.		JULY 1 1966		19		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
PENNSYLVANIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Memorial Hospital (DOA)		STUDENT		COLLEGE											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
VIRGINIA		LOUDOUN		LEESBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		316 NANSMOND ST. S.E.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
JEFFREY		FLORA		NO		224-27-0493		FLORA L. FOCER								316 NANSMOND ST. S.E. LEESBURG, VA. 22075	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Thoraco-abdominal trauma</u>		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
8/20		Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>12:20</u> MONTH <u>8</u> DAY <u>16</u> YEAR <u>1985</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Driver of auto/tractor trailer collision.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
		road		Rt. 40 w. of Street Rd., Martins Mountain,		Allegany Co.											
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE		8-17-85							
ACTUAL SIGNATURE		M.D. Assistant		MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		8/20/85		UNION CEMETERY		LEESBURG		LOUDOUN		VA.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
COLOMAN FUNERAL HOME OF LEESBURG		AUG 23 1985		John Davidson													

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 OF THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH IF FROM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/14  
25M  
DHMH - 12  
(VR A15 ME (5))

2022 COLLECTION LIBER

2022

2022

2022



110115



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

227099

1. DECEASED NAME (TYPE OR PRINT) PETER A. FRANKLIN			2a. DATE OF DEATH MONTH DAY YEAR August 7, 1985		2b. HOUR 2:45 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 29, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.			13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	
14. FATHER'S NAME FIRST MIDDLE LAST Frank - Franklin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - Cabacio		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW 11		16b. SOCIAL SECURITY NO. 236-03-8165		17. INFORMANT ADDRESS Doris G. Franklin Rt 4 Keyser, W. Va.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Augusto F. 2		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8 Aug 1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Augusto Figueroa		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9 Aug 85	23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.VA.
24. FUNERAL DIRECTOR NAME ADDRESS Allen Rotruck Keyser, W.VA.		25a. DATE REC'D. BY REGISTRAR AUG 12 1985	25b. REGISTRAR'S SIGNATURE John Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Page 1 and 2 and place them in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

000755

White Male  
West Virginia U.S.A.

1121, 23 2000

Ministry of Education - Department of Education

Doris G. Franklin At A Keyser, Va.

5421394

0192920150

240067

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (1))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21271

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William Harold Freeland</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>8-21 19 85</b>			2b. HOUR <b>7:30</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 25, 1905</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>80</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>8/21 19 85</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 N. Liberty St. Apt. 401</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>705-05-4398</b>			17. INFORMANT ADDRESS <b>Dorothy V. Freeland same as 13a-e.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John M. Hartman</i>			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>8/24/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg Wash. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leasure-Stain Funeral Home, Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1985</b>			25b. REGISTRAR'S SIGNATURE <i>John M. Hartman</i>		
230 Baltimore Ave. Cumberland, MD 21502								

240084

DAVID WILKINSON

1012 10100 2002

1012 10100 2002

246026

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

21272

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul H Garlitz			2a. DATE OF DEATH MONTH DAY YEAR 8 16 85			2b. HOUR 6:10PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 1 98		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Laboratory	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Kaylor Circle, 21532	
14. FATHER'S NAME FIRST MIDDLE LAST Enoch Garlitz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Mc Kenzie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 05 8690		17. INFORMANT ADDRESS Mary N. Garlitz, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ADVANCE RHEUMATOID ARTHRITIS</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 14</u> , 19 <u>85</u> , to <u>AUGUST 16</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Chang M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Aug. 16, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SATURNINA T. CHANG, M.D.</u>						22e. ADDRESS <u>FROSTBURG PLAZA FROSTBURG, M.D. 21532</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 19 1985		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Allegany, Md.		
24. FUNERAL DIRECTOR Durst Funeral Home, Frostburg, Md.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 21b shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

AUG 23 1985



RECEIVED  
MAY 1964  
COMMUNICATIONS SECTION

COMMUNICATIONS SECTION



238078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21273

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Walter		MIDDLE M		LAST Garrison		2a. DATE KNOWN OF DEATH		ESTIMATED 8 12 85 19		2b. HOUR M	
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 8 14 1935		6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 8 12 85 19		2d. HOUR M 1719	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH Midland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 205 Paradise St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 205 21542					
14. FATHER'S NAME FIRST MIDDLE LAST James H. Garrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Almeda Harman				17. INFORMANT ADDRESS Mrs. Patricia Garrison Midland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) .10		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 220-32-4044									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Chronic alcohol abuse Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMINATION Sudden years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Paul Snow M.D.				M.D. Dpty				MEDICAL EXAMINER				DATE SIGNED 8-12-85	
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow M.D.				ADDRESS Memorial Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/15/85		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery				23d. LOCATION Midland Allegany COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME Wayne Boulton				ADDRESS Boals Funeral Service Lonaconing, Md. 21539				25a. DATE REC'D. BY REGISTRAR AUG 10 1985				25b. REGISTRAR'S SIGNATURE	



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James

Chambers

James

James

to

320-2-04

W. J. Johnston

Johnston

Johnston

Johnston

Handwritten notes and markings, including a large circular stamp with the number 10 inside.

Paul Jones

Johnston

8/15/35

St. Joseph County

William Liberty

Johnston

240102

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

SCARPELLI FUNERAL HOME 108 VIRGINIA AVENUE CUMBERLAND, MD 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 21274			
1. DECEASED NAME (TYPE OR PRINT) EDWARD BENJAMIN GORDON SR.				2a. DATE OF DEATH MONTH DAY YEAR 08 16 85				2b. HOUR 9:47 A.M.			
3 SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10-02-1944		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY Transit Co.			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 206 Arch Street/21502			
14. FATHER'S NAME FIRST MIDDLE LAST James H. Gordon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annabel Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215424877		17. INFORMANT ADDRESS Mrs. Janet Gordon, Cumberland, MD - wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Relaxation to brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Out cell ca of the lung</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-07-1981</u> to <u>8-16-1981</u> , that (I) (we) lost saw the deceased alive on <u>8-16-1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John Mehan</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-18-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-19-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

369105

38110100 2602

SCARLETT PETERSON  
100 VIRGINIA AVENUE  
DALLAS, TEXAS

EXHIBIT      RETURN      ADDRESS      DATE

ALLIANCE COUNTY

SACRED HEART HOSPITAL

ST. LOUIS

6-1-50      100-1-50      100-1-50

BOALS FUNERAL HOME

STATE OF MARYLAND

FOR 111 CHURCH STREET  
1 - STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
REGISTRAR WESTERNPORT, MD 21562

## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLYDE ALFRED GRADY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 9, 1985</b>		2b. HOUR <b>12:43P</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 18 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>75</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF BUSINESS OR MOST OF WORKING LIFE) <b>LABORER</b>	12b. KIND OF BUSINESS OR <b>PAPER MILL</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b> 13b. COUNTY <b>MINERAL</b> 13c. CITY OR TOWN <b>PIEDMONT</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>53 3rd St. PIEDMONT, WV. 26750</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE M. GRADY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE LEE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2 217-05-0193</b>		17. INFORMANT ADDRESS <b>MARY GRADY PIEDMONT, WV.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardio-Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>Aug 9 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L.R. MILES, JR. M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L.R. MILES, JR. M.D.</b>		22e. ADDRESS <b>BMG-912 SETON DRIVE, CUMBERLAND MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>AUGUST 11, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BLOOMINGTON CEMETERY</b>	23d. LOCATION <b>BLOOMINGTON GARRETT MD. STATE</b>		
24. FUNERAL DIRECTOR <b>BOALS FUNERAL SERVICE, P.A. WESTERNPORT, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

HOME FURNACE HOME  
111 CROWN STREET  
BOSTON, MA 02102

30000

CLYDE ALFRED GRADY AUGUST 2, 1962 12:12P

JULY 18 1962

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ALLERMAN COUNTY

ALLERMAN COUNTY

SPRING HART HOSPITAL

22 3rd St. BOSTON, MA 02102

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017-02-0102 N-HY GRADY 017-02-0102, V.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 21276

228137

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY JEAN GRAY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 12, 1985		2b. HOUR 10:10A. M						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 13, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 628 Lincoln St./ 21502			
14 FATHER'S NAME FIRST MIDDLE LAST Daniel A. Swarner						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes K. Irvine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-03-7575		17 INFORMANT ADDRESS Walter P. Gray, Cumberland, MD							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neurological condition - cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SAH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>85</u> , to <u>8/12</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. P. JAMES</u> M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. JAMES						24 ADDRESS 441 N. Centre St. Cumberland, Maryland 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 15, 1985			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial P.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24 FUNERAL DIRECTOR NAME William G. Kight						ADDRESS Cumberland, MD			25a. DATE REC'D. BY REGISTRAR AUG 14 1985		
						25b. REGISTRAR'S SIGNATURE <u>W. P. JAMES</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

William G. Knight  
 Cumberland, MD  
 Burial Aug 15, 1988 Sunset Memorial P. Cumberland Allegany MD

No

Daniel

A.

Swanner

Agnes

K.

Irving

Walter P. Gray, Cumberland, MD

MD

Allegany

Cumberland

K

628 Lincoln St. \ 21502

Housewife

Own Home

MD

USA

Allegany

Female

White

Mar. 13, 1913

72

202137



254008

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joanne S Green</b>			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 8-30 19 85			2b. HOUR M 4:30 P. M	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 29 1933 52</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>52</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8-30 19 85</b>	7d. HOUR M <b>4:30 P.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Community Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LONA CONING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HOWARD SKIDMORE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELVIRA DAVIS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>EARL GREEN 5 BUCK HILL LONA CONING, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8120 IMMEDIATE CAUSE (a) Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>4:15PM 8-30 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver in auto/truck impact</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 36 &amp; Rt.55, Frostburg, Allegany Co., Md.</b>			
22a. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) <b>Assistant MEDICAL EXAMINER</b>				DATE SIGNED <b>8-31-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>SEPT. 3, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG ALLEGANY MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Eds Funeral Service</b>		ADDRESS <b>Westernport, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 05 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

66

JUL 29 1 33 PM

X

NEW

STANDARD

STANDARD

STANDARD

X

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD



241085

Silcox-Merritt Funeral Home  
 1- FOR 404 Decatur Street  
 STATE REGISTRAR CUMBERLAND, MD 21502  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dennis Ambrose Griffin			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1985			2b. HOUR 3:35a M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 11 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED KELLY TIRE CO.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1821 BEDFORD STREET 21502	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES GRIFFIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILHELMINIA HARTUNG						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS RUTH GRIFFIN 1821 BEDFORD ST CUMBERLAND MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic adenocarcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>of lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (do) (not) touch the body after death.							
22b. SIGNATURE <i>Gary Wagoner</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-19-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Wagoner, M.D.				22e. ADDRESS 925 Bishop Walsh Road, Cumberland, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 21 1985		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE <i>John Gordon Rendell</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

211082

Alison-Henrichs, Pamela  
4000 North Street  
Oxnard, CA 91320

James  
Address  
Oxnard, California  
August 12, 1988  
211082

Alimony County

County Court Judicial



211082

X

Only members, N.D.  
2025 Bishop's School Road, Oxnard, CA 91320

238132

ROTRUCK FUNERAL HOME  
85 S. MAIN ST.  
KEYSER, WV 26726

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21279

1. DECEASED NAME (TYPE OR PRINT) JOHN MARTIN HAINES			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1985			2b. HOUR 00:30A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS RD, B and O Rail.		
13a. STATE W. Va.					13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John I. Haines					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa B. Swick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT (Rt 4 Box 314) Lois Haines 156 Front St. Keyser, W. Va.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hepatic coma.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cerebral aneurysm of the liver.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hepatic non A - non B

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

diabetes.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-8-1985 to 8-10-1985, that (I) (we) last saw the deceased alive on 8-9-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Melanna H.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-10-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MEHANNA, M.D.				22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 13, 85		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. VA.	
24. FUNERAL DIRECTOR NAME Allen Rotruck Keyser, W. VA.				25a. DATE REC'D. BY REGISTRAR AUG 19 1985		25b. REGISTRAR'S SIGNATURE John H. Haines	

BP

384113

JOHN H. KEYSER, JR.  
100-2-20000, M.D.  
100-2-20000, M.D.

NAME	DATE OF BIRTH	SEX	RACE	U.S.A.	RESIDENCE	EDUCATION	EMPLOYMENT	REMARKS
John H. Keyser, Jr.	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	
John I. Keyser	Nov. 13, 1921	Male	White	U.S.A.	Retired	High School	Band O Rail.	

100-2-20000, M.D.

John H. Keyser, Jr.  
100-2-20000, M.D.  
100-2-20000, M.D.

242190

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21280

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph F. Hauser</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>8-21 19 85</b>			2b. HOUR <b>305</b> AM		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 17, 1922</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>Aug. 21, 1985</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>El. Local</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>222 Pear St. 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Floyd C. Hauser</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anastasia Mullen</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>215-14-6560</b>		17. INFORMANT ADDRESS <b>Wife</b> <b>Mrs. Mary Margaret Hauser, Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for Part I) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>m</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Dr. Giovanni Mastrangelo</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>8-21-1985</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Giovanni Mastrangelo MD</b>			ADDRESS <b>900 Seton Drive, Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-23-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oldtown, Allegany, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>James F. Scarpella</b> ADDRESS <b>Cumberland, Md. 21502</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1985</b>		25b. REGISTRAR'S SIGNATURE <b>G. Davidson-Rodwell</b>		



John J. [unclear]

10.13.18

232023

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RANDY WARD HERLINE			2a. DATE OF DEATH MONTH DAY YEAR 08 08 85		2b. HOUR 7:07 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 06 70		
6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CNTR		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education		13. STREET ADDRESS / ZIP CODE R. D. 1, 15550		
14. FATHER'S NAME FIRST MIDDLE LAST H. WARD HERLINE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FAYE SHROYER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
17. INFORMANT H. Ward Herline		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		19. DATE OF OPERATION 1985		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1030 P.M. 8 8 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Fall from</u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Self City, Penn</u>		21f. LOCATION CITY OR TOWN COUNTY STATE <u>Bedford</u> <u>Bedford</u> <u>PA</u>		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <u>John G. Stansbury, M.D.</u>		22c. ADDRESS MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND MD 21502		22d. DATE SIGNED 8/8/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug 12 1985		23c. NAME OF CEMETERY OR CREMATORY Bedford Co. Mem. Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Bedford Bedford PA		24. FUNERAL DIRECTOR NAME ADDRESS Jack H. Geisel, Jr. Schellsburg, PA 15559		25a. DATE REC'D. BY REGISTRAR AUG 14 1985		
25b. REGISTRAR'S SIGNATURE <u>John G. Stansbury</u>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate and Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

335023



COTTON FIBER

Handwritten text, possibly a signature or date.

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246090

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE M. HOWDYSHELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 23, 1985</b>				2b. HOUR <b>12:05 P.M.</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08-04-1910</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. STATE <b>MD</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>123 Oak Street/21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Ryan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mahalia Northcraft</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216-38-1604</b>		17. INFORMANT ADDRESS <b>Mr. Charles R. Howdysshell, Cumberland, MD</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c): PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1 day</b>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> 19 <b>85</b> , to <b>8/23</b> 19 <b>85</b> , and that (I) (we) last saw the deceased alive on <b>8/23</b> 19 <b>85</b> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Guy Fiscus</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>8/26</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Guy Fiscus</b>	
22e. ADDRESS <b>Memorial Hospital Medical Building Cumberland, Md 21502</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>08-26-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, event, the medical examiner must be notified at once.

248030

20% COLD M. FIBER



WILKINSON  
BOWEN

234095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21283

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>CHARLES</b>		MIDDLE <b>William</b>		LAST <b>Howell</b>		2a. DATE KNOWN OF DEATH		MONTH <b>8</b>		DAY <b>10</b>		YEAR <b>1985</b>		7b. HOUR <b>10:00 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 17 1919</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 10 1985</b>		7d. HOUR <b>11:45 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>				MD.			
10. CITY OR TOWN OF DEATH <b>Lonaconing</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>53 Main St. Lonaconing Md.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Allegany</b>				13c. CITY OR TOWN <b>Lonaconing</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>53 Main St Lonaconing Md.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Howell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Lodgson</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W. W. 2 220-10-1323</b>				17. INFORMANT ADDRESS <b>Mrs Annie Howell Lonaconing Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>Francisco Reyes</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>8-10-85</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes</b>				ADDRESS <b>900 Seton Dr. Cumberland, Md. 21502</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9/11/85</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg Allegany Md.</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Boal Funeral Service Lonaconing Md.</b>				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <b>Richard Davidson-Randall</b>											

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN OBITUARY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHAM-17  
IVR A15 ME (5)  
15M 7/76

AUG 14 1985

Case	Date	White	Black	Other
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100
100-10-100	10-10-10	100	100	100

100-10-100 10-10-10 100 100 100



225005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

George-Upchurch Funeral Home, STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				21284			
1- FOR STATE REGISTRAR 202 Green Street Cumberland, MD 21502				CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Donald H. Humbertson</b>				2a DATE OF DEATH MONTH DAY YEAR <b>August 5, 1985</b>				2b HOUR <b>3:00a M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 20, 1935</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>sacred Heart Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Loading Warehouse</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Kelly-Springfield</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a STATE <b>Maryland</b>				13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cresaptown</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Henry Humbertson</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Ethel Truax</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b SOCIAL SECURITY NO. <b>218344354</b>		17 INFORMANT <b>Alice Stickley</b>		ADDRESS <b>117 E. Mary Street Cumberland, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Upper Gastrointestinal Hemorrhage</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>NFS</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Circuits on, Environmental Variables</b>											
19a DATE OF OPERATION <b>7/15/85</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1985</b> , to <b>Aug 5, 1985</b> , that (I) (we) last saw the deceased alive on <b>Aug 5, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Bruce Behounek</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/5/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce Behounek, M.D.</b>				22e. ADDRESS <b>BMG, 912 Seton Drive</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/7/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland-Allegany Co.-Md.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>			

BP

825005

General Hospital  
302 West Street  
Cambridge, MA 02102

Female  
N. Davidson  
August 5, 1985  
3:00a

Albany County

General Hospital

Signature

James Stewart, M.D.  
Sgt. 312 Hobbs Drive

240068

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or a completely qualified person, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of one.

LEASURE-STEIN FUNERAL HOME STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				21285	
1- FOR STATE REGISTRAR 230 BALTIMORE AVENUE CUMBERLAND, MD 21502				CERTIFICATE OF DEATH	
1. DECEASED NAME				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
EMMA VIOLA HURT				AUGUST 21, 1985	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Black		MONTH DAY YEAR	
				3/25/88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
Virginia		U.S.A.		97 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland		SACRED HEART HOSPITAL		ALLEGANY COUNTY, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Allegany		Cumberland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Thomas		Crawley		Mitt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		218-30-0702		James F. Hurt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ADDRESS	
Carcinoma bladder with metastases				111 N. Walnut Street	
DUE TO, OR AS A CONSEQUENCE OF				Cumberland, MD 21502	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. PROBABLE INTERVAL BETWEEN ONSET AND DEATH	
(b) _____				8 mos.	
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-13, 1985, to 8-21, 1985, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
SUSAN SCHWARTZ, M.D.				8/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
SUSAN SCHWARTZ, M.D.				FROSTBURG, MD 21532	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE	
Burial				8/26/85	
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Belleville Cemetery				Suffolk Virginia	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR	
Leasure-Stein Funeral Home, Inc.				25b. REGISTRAR'S SIGNATURE	
230 Baltimore Ave. Cumberland, MD 21502				AUG 26 1985	

BP

210000

LEASING STATION  
330 WATKINS AVENUE  
CHICAGO, IL 60602

11-15

11-15

11-15

11-15

11-15

ALLEN COUNTY

SACRED HEART HOSPITAL



218-20-0702



POSTING, IL 60602

POSTING, IL 60602

POSTING, IL 60602

232022

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS T. JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 3, 1985</b>		2b. HOUR <b>5:35</b> pm				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6/12/1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Country Club Rd. / 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam H. Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matilda Donaldson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-54-6926</b>		17. INFORMANT ADDRESS <b>Finan Center - Cumberland, MD</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CHF**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **ASCVD - A-fib**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

ATTENDING  
PHYSICIAN ☐ MEDICAL  
DIRECTOR ☐ STAFF  
PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**Dr. H. C. Merrick****500 Memorial Ave., Memorial Med. Bldg.  
Cumberland, MD 21502**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alleg. Cty. Ceme.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Alleg., MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John J. Hafer, Jr. LaVale, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

5

220027

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Timothy Bone Johnson				MONTH DAY YEAR 8 2 85				M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
Male		White		MONTH DAY YEAR 5 1 11				74 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
United States		United States						Allegany County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg		Frostburg Community Hospital				Mail Carrier				Postal	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				Allegany		Eckhart		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. box 148 / 21528	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Oscar Leroy Johnson				FIRST MIDDLE LAST Slona Crowe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
Yes		WW II		215-16-4807		Myrtle R. Johnson - same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										10 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular accident											
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Thrombosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 Severe Cerebral Failure - COPD. Renal Failure											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/17/80, 1985, to 8/12, 1985, that (I) (we) lost saw the deceased alive on 8/12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE S.L. Sandhir				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S.L. Sandhir				22e. ADDRESS Frostburg Comm. Hospital 48 Tarn Terrace							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		8/5/85		Eckhart Cemetery		Eckhart, Allegany, MD					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr. Frostburg, MD				AUG 6 1985				Davidson-Randall			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20002



John L. Baker, Jr. President, The American Society of Mechanical Engineers  
5/2/53  
United States Department of Commerce, Washington, D.C.

228076

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM EMB-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR 115 ME (1))  
15M/2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21288

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine A. Kelly						2a. DATE KNOWN OF DEATH ESTIMATED 08-01 1985			2b. HOUR 3:30 a.m.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02-03-1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 08-01-85 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 419 Washington Street			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired secretary				12b. KIND OF BUSINESS OR INDUSTRY textile				13a. STREET ADDRESS 419 Washington Street/21502			
13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John P. Kelly						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Footen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-1754				17. INFORMANT ADDRESS Mrs. Mary Kay Finan, Cumberland, MD-niece			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Primary Carcinoma of Bladder (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Giovanni Mastrangelo				M.D. _____ MEDICAL EXAMINER				DATE SIGNED _____			
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.				900 Seton Dr. Cumberland, Md. 21502 ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 08-03-1985		23c. NAME OF CEMETERY OR CREMATORY SS Peter Paul Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				ADDRESS				25. REGISTRAR'S SIGNATURE DATE RECD. BY REGISTRAR Juba Davidson-Randall			

19-10-1960

10000

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235024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1a. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ADVISING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERRIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21289

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST Susan M. Ketterman			
2a. DATE KNOWN OF DEATH		2b. HOUR	
ESTIMATED MONTH DAY YEAR 8 10 19 85		1:20 PM	
3. SEX F		4. RACE W	
5. DATE OF BIRTH MONTH DAY YEAR 10-01-1905		6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Allegany	
13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 28 E Industrial Blvd.		14. FATHER'S NAME FIRST MIDDLE LAST (nfn)	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (nmn)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 215-20-7157		17. INFORMANT ADDRESS Mrs. Eleanor M. Knoche, Cumberland, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of bowel</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Probably due to arteriosclerotic Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Cancer of the colon with liver metastasis.</u>			
19a. DATE OF OPERATION 8-9-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Abdominal pain	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francisco Reyes</u>		TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <u>Francisco Reyes</u>		DATE SIGNED <u>8-10-85</u>	
ADDRESS <u>900 Seton Dr. Cumberland Md 21502</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-13-1985	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR AUG 15 1985	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of" are faintly visible.]*



246093

1. FOR  
STATE  
REGISTRARSILCOX-MERRITT FUNERAL HOME  
404 DECATUR STREET  
CUMBERLAND, MARYLANDSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21290

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN FRANCIS KIENHOFFER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1985		2b. HOUR 23:42P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 10 1911		
6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED CELENESE		12b. KIND OF BUSINESS OR INDUSTRY CORP. SILK		13a. STATE MARYLAND		
13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 523 WARREN STREET 21502		14. FATHER'S NAME FIRST MIDDLE LAST JOHN KIENHOFFER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE KELLY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-5175		17. INFORMANT ADDRESS MARGARET KIENHOFFER 523 WARREN ST CUMBERLAND		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Aortic Aneurysm, old

DUE TO, OR AS A CONSEQUENCE OF

(b)

AS 180

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 day

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George M. Breza		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE M. BREZA		22e. ADDRESS BMG, 912 SETON DR., CUMBERLAND, MD. 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 29 1985		23c. NAME OF CEMETERY OR CREMATORY SUNSET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall	

248093

STATION - BUREAU OF INVESTIGATION  
FOR INSURANCE PURPOSES  
CHICAGO, ILLINOIS

DATE: 10-10-35  
BY: [illegible]  
RE: [illegible]

WILLIAM Y. [illegible]

CHICAGO, ILLINOIS

10-10-35



X

248093, CHICAGO, ILLINOIS



246021

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21291

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR									
1. DECEASED NAME (TYPE OR PRINT)		Fred D. Kitzmiller									
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	8 11 19 85				2d. HOUR
Male	White	April 9, 1908	77 YRS.			8 11 19 85	1800				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		U.S.A.				Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
McCoole		Rt. 135				Retired		US Army			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		26726	
Maryland		Allegany		McCoole				Rt. 135			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edward - Kitzmiller						Manda - Writtenhour					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				WW 11		441 28 6047 Fred D. Kitzmiller, Jr. Concord, CA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF Coronary artery heart disease											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
Oct 1980				PACER MAKER IN SECTION				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Paul Snow				Dpty				8-11-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Paul Snow				Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				15 Aug 85		Potomac Mem. Gardens Keyser				Mineral W.Va.	
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Allen Rotruck Keyser, W.VA.						AUG 21 1985		John Davidson Handall			



228097

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please return carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
SCARPELLI FUNERAL HOME 1 - STATE REGISTRAR 108 VIRGINIA AVENUE CUMBERLAND, MD. 21502					REG. NO. 21292				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS HARRY KOONTZ					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 3, 1985			2b. HOUR 11:20A	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-28-1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN LaVale 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 513 B Street/21502				
14. FATHER'S NAME FIRST MIDDLE LAST George Koontz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Breighner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-07-2013		17. INFORMANT ADDRESS Mrs. Catherine H. McKenzie, LaVale, MD-wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Esophageal-bronchial fistula</i> DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/15</i> , 19 <i>83</i> , to <i>8/3</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/3</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.									
22b. SIGNATURE <i>Richard Snider</i> DECEASED ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <i>8/5/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RICHARD SNIDER, M.D.								22e. ADDRESS P.O. BOX 2455, CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-06-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR AUG 09 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

328037

SCARLETT FURNACE HOME  
108 VIRGINIA AVENUE  
DUNSTON, MD. 21502

FRANCIS

HARRY

ROBERT

AUGUST 21, 1962

11:30

ALLIANCE CHURCH

SECOND FIRST SERVICE

214-05-2012

P.O. BOX 9822, DUNSTON, MD. 21502

DR. RICHARD SMITH, MD.

238073

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5

2 1 2 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARK MENKIN KROLL</b>			2a. DATE OF DEATH MONTH <b>Aug</b> DAY <b>13</b> YEAR <b>85</b>			2b. HOUR <b>3 45</b> AM				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>27</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Doctor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Seneca Ave. 21502</b>	
14. FATHER'S NAME FIRST <b>Barnet</b> MIDDLE <b>Kroll</b> LAST <b>Kroll</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rose</b> MIDDLE <b>Menkin</b> LAST <b>Menkin</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) <b>WWII 220-44-3407</b>		17. INFORMANT ADDRESS <b>Mr. Marvin Kroll Baltimore, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>not known</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>not known</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 23</b> , 19 <b>85</b> , to <b>Aug 13</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>July 23</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8 13 85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>8/13/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION <b>Smithsburg Washington Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Wayne Boals</b> <b>Boals Funeral Service P.A.</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1985</b>					
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>										

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

200000

Male

White

7

27

1908

NY

New Jersey

U.S.A.

x

Investing

Investing

Investing

Investing

Female

White

Investing

x

Investing

Investing

Investing

Investing

Male

White

Investing

Investing

Investing



200000

Investing

Investing

Investing

Investing

Investing



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# SILCOX/MERRITT FUNERAL HOME/CITY OF MARYLAND

404 DECATOR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LAUREN CLIFTON LAPP		AUGUST 29 1985		5:50 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE	WHITE	APRIL 6 DAY 1922		63	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	USA			ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL		DRIVER MATTINGLY & STOTLER DIST		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
MD		ALLEGANY	CUMBERLAND	514 LOWELL AVE. 21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
HERBERT H. LAPP		ADA LEE ERVIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
YES		WWII 217-14-4073		BETTY LAPP 514 LOWELL AVE CUMBERLAND MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					
Metastatic Cancer					
DUE TO, OR AS A CONSEQUENCE OF					
Lung Cancer					
DUE TO, OR AS A CONSEQUENCE OF					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4 months					
5 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 8/29 1985 to 8/29 1985 that (i) (we) last saw the deceased alive on 8/29 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Rb Schmitt MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
RICHARD SCHMITT, MD		BMG 912 SETON DRIVE CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		SEPT 1 1985		REST LAWN MEMORIAL PARK LAVALE ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD				SEP 03 1985	
				25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



230539

242127

FOR Film G607 item 8  
1- STATE REGISTRAR 9/10/85 rjaSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Clara H. Lavin			2a. DATE OF DEATH MONTH DAY YEAR 8/13/85			2b. HOUR 12:55pm			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8/4/01		6 AGE (IN YEARS LAST BIRTHDAY) 80 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Alleg. County MD.			
10 CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a STATE MARYLAND			13b COUNTY ALLEGANY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS / ZIP CODE 1 Kaylor Circle 21532		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY MICHAELS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE PARKER			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b SOCIAL SECURITY NO. N.A.			17 INFORMANT MR. DALE LAVIN, RT 3, BOX 398,			17b ADDRESS FROSTBURG, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Coronary heart failure - pleurisy, both</i> (c) <i>Diabetes mellitus, hyperlipidemia</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Renal failure, CAD - original</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two) (add) (do not) view the body after death.									
22b SIGNATURE <i>Dr. C. Oh</i> 22c PHYSICIAN'S NAME (PRINT) Dr. C. Oh					DEGREE M.D. 22d ADDRESS Frostburg, MD 21532			22e. DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ECKHART ALLEGANY MD		
24 FUNERAL DIRECTOR <i>Mr. Sowers</i> Sowers Funeral Home					25a. DATE REC'D. BY REGISTRAR 10/2/85				

1934

UNITED STATES GOVT

208 COLUMBIA STREET

CHANDLER

CHANDLER ALL DAY PROCEEDING

WILLIAM

HENRY NICHOLS

ALICE

RECEIVED

RECEIVED

TO T.A. 1000 N. 10th Street, N.W. WASH. D.C. 20004



UNITED STATES GOVERNMENT ALL DAY

UNITED STATES GOVERNMENT

225023

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21296

1. DECEASED NAME (TYPE OR PRINT) William F. Lux			2a. DATE OF DEATH MONTH DAY YEAR August 3, 1985			2b. HOUR 3:06 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep-American Cynamid		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 726 Valley View Dr/ 21502	
14. FATHER'S NAME FIRST MIDDLE LAST William Lux					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Florence G. Lux-Address same as #13 above.		ADDRESS			

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Massive Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-7-1976, to death, 1985, that (I) (we) lost saw the deceased alive on 8-2-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gary Wagoner M.D. for U. Velozinda M.D.				22c. DATE SIGNED 8-4-85		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Wagoner, M.D.				22f. ADDRESS 925 Bishop Walsh Rd-Cumberland, Md. 21502			

23a. BURIAL, CREMATION, REMOVAL SPECIFY Cremation		23b. DATE 8/5/85		23c. NAME OF CEMETERY OR CREMATORY Rosedale Funeral Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg-Berkeley-West Va.	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR AUG 8 1985		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

552023

LOWE'S

DEPT. 1

MADE IN U.S.A.  
100% COTTON

Blank lined paper with faint horizontal lines and a large rectangular border.



256005

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAE ALMA MARGHERITA		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 31, 1985		2b. HOUR 10:48 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1911	
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		8. CITIZEN OF WHAT COUNTRY? USA	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home		13. STREET ADDRESS / ZIP CODE 39 Bridge St. 28753	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Raso		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret nm		16. SOCIAL SECURITY NO. 820-01-4794	
17. INFORMANT Mrs. Patsy Jenkins, Ridgeley, W. Va.		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unseen</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 years</u> <u>1 month</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George B. B. MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRADDOCK MEDICAL GROUP		22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-3-1985		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

228002

SCARPELLI FRANK JONE  
108 VIRGINIA AVENUE  
CHICAGO, ILL. 60602

10:42

21:10:22

ALBERT

WESTERITA

WILL

WILL

ALLEGANY

SARIE NEWAT HOSPITAL

220-01-4700

213 BETON DRIVE, CHICAGO, ILL. 60602

BRADDOCK HOSPITAL



228095

1- FOR  
STATE  
REGISTRARSCARPELLI FUNERAL HOME  
108 VIRGINIA AVENUE  
CUMBERLAND, MD 21502STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21298

1. DECEASED NAME (TYPE OR PRINT) JAMES NMI MARKER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 3, 1985			2b. HOUR 3:15P M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-30-1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) driver/salesman		12b. KIND OF BUSINESS OR INDUSTRY snack foods	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 Long Drive/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Edward C. Marker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Parker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW II 217-10-6770		17. INFORMANT ADDRESS Mrs. Mildred D. Marker, Cumberland, MD-wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a GI Bleeding									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 2, 19 85, to Aug 3, 19 85, that (I) (we) lost the deceased alive on Aug 3, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE Paul J. Livengood MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-4-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. EUGENE MAZZOCCO, M.D.						22e. ADDRESS BMG-912 SETON DRIVE, CUMBERLAND, MD21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08-06-1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Ashby Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Ashby Mineral WV		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD						25a. DATE REC'D. BY REGISTRAR AUG 09 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

023035

SCARBOROUGH FURNACE  
108 VIRGINIA AVENUE  
CHICAGO, ILL. 60605

JAMES J. JAMES  
MARKER  
AUGUST 2, 1982  
SHIP

ALLEYWAY CO. LTD.

SACRED HEART HOSPITAL

017-10-0770



V. EUGENE WATKINS, M.D.  
240-111 25TH DRIVE, CHICAGO, ILL. 60605

227135

EICHORN FUNERAL HOME

MAIN STREET

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

LONA CONING, MD 21539

1. DECEASED NAME (TYPE OR PRINT) EVELYN WEBER MATHENY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 6, 1985		2b. HOUR 5:00P M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 20, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Owner Variety Store	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Lonaconing	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 2 Pershing St. 21539		
14. FATHER'S NAME Frederick Weber		15. MOTHER'S MAIDEN NAME Margaret Anderson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none	17. INFORMANT ADDRESS Claude Matheny 2 Pershing St, Lonaconing, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver &amp; Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Wayne Spiggle MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-8-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE SPIGGLE, M.D.			22e. ADDRESS BMG-912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL CREMATION REMOVAL (SPECIFY)	23b. DATE Aug. 9, 1985	23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION Frostburg Allegany Md		
24. FUNERAL DIRECTOR Eichorn Funeral Home, Lonaconing, Md.			25a. DATE REC'D. BY REGISTRAR AUG 13 1985			
25b. REGISTRAR'S SIGNATURE <u>John Andrew Rodale</u>						

2015 4P 15

ALLIANCE COUNTY

576-01-2876

242120

STATE OF MARYLAND  
 1- FOR MARKWOOD FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 REGISTRAR 11 MINERAL ST. KEYSER, WV. CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELVIN GILBERT MCBEE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15, 1985		2b. HOUR 6:48 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1911		
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		
12b. KIND OF BUSINESS OR INDUSTRY Lumber Mill						

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN McCoole	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 625 N. Main Street 21562			
14. FATHER'S NAME FIRST MIDDLE LAST Russell - McBee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agatha UNK.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11 217104698		17. INFORMANT Mr. Ronald G. McBee, 13904 Parkland Drive		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Crownary art. Dis.</u>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypertension</u> <u>Exogenous Obesity</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
--	--	--	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
---	--	--	--	---	--

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
---	--	--	--	--	--

22b. SIGNATURE <u>C. Vincent M.D.</u>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT, M.D.		22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORY Omps Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Winchester Frederick, Va.	
--	--	----------------------	--	--	--	---	--

24. FUNERAL DIRECTOR NAME Markwood-McKenzie Funeral Home Harold W. McKenzie, 111 S. Mineral St. Keyser, W. Va.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>	
--	--	--	--	-------------------------------	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

021610

HAROLD F. M. 1947  
11 HUNTER ST. EYRE, N.Y.

6:00 P. AUGUST 15, 1965 ALBERT MOORE MELVIN

ALLEANY COUNTY

SACRED HEART HOSPITAL



021610

*Handwritten notes:*  
C. L. 1947  
V. 1947  
C. L. 1947  
V. 1947  
C. L. 1947  
V. 1947

*Handwritten signature:* C. L. 1947

CLARENCE VINCE T. M. 1947 3000 ALTON DRIVE CLARE, MD. 21503

200 HUNTER ST. EYRE, N.Y. 12116  
HAROLD F. M. 1947  
11 HUNTER ST. EYRE, N.Y. 12116

234019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

21301

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James NMN McCarty</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8/14/85</b>		2b. HOUR <b>245 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS <b>88</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nsg. Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dispatcher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. McCarty</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May Deetz</b>		16. STREET ADDRESS <b>322 Mountainview Drive</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>705-05-4478</b>		17. INFORMANT <b>Mary Malone</b>	
17a. ADDRESS <b>Cumberland, MD</b>		17b. ADDRESS <b>21502</b>		17c. ADDRESS <b>21502</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY: **Cardiac Arrest**  
IMMEDIATE CAUSE (a) **Cheyne-Stokes Respiration**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

24 Hr.

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Multiple Myeloma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

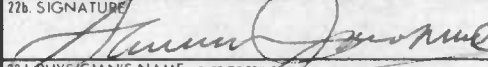
2 Yr.

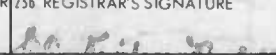
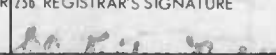
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Calcification Aorta, Parkinsonism, Osteoporosis, Hypertrophic Arthritis.**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **Feb. 3, 19 53**, to **Aug. 13, 19 85**, that (I) (we) last  
saw the deceased alive on **Aug. 13, 19 85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 	DEGREE	22c. DATE SIGNED <b>8/14/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel M. Jacobson, M. D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS <b>50 Pershing St., Cumberland, Md. 21502</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/16/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Alleg. MD</b>
24. FUNERAL DIRECTOR NAME <b>Leasure-Stein Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1985</b>	
25b. REGISTRAR'S SIGNATURE 		25c. REGISTRAR'S SIGNATURE 	

230 Baltimore Ave. Cumberland, MD 21502

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. The original should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

filled in by the funeral director, page 3  
should be filed within 72 hours after death



23010

James

W. H. B. 2/4/52

1/1/52

Continued 150 Hubs



Continued 150 Hubs

2/1/52

Continued 150 Hubs

2/1/52

Continued 150 Hubs

X

Continued 150 Hubs

Continued 150 Hubs

Continued 150 Hubs

Continued 150 Hubs

2/1/52

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

21302

REG. NO.

242007

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
James Taylor McClellan								08 20 85								11:00	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	white	09 17 1932		52 YRS.						08 20 85						11:20 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		United States				Allegany County, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Sacred Heart Hospital		Liquor Control/Montgomery County Government													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Kensington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3715 Nimitz Road / 20895									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Robert Edward McClellan		Ethel Marie McKenzie															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		215-26-6607		Mrs. Guindalina Gagnon, Daughter,		Same as item #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION, PROBABLE															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) CORONARY ARTERY DISEASE															
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
Giovanni Mastrangelo, M.D.		DEPUTY				8-20-85											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		August 24, 1985		Parklawn Memorial Park		Rockville											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland		AUG 28 1985		Jana Davidson-Henderson													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

213007

08 20 22 11:00  
08 20 22 11:00  
08 20 22 11:00

Order of the Secretary of the Interior

CONVICTED AND RE-ENTRY  
RECEIVED

900 Series (1910-1919) (1910-1919)



246106

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

21503

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wesley A. McGraw, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 8-24-85		2b. HOUR 5:30 PM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 22 97		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS 1 MONTH 2 DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nsg. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Amelle Celanese Corporation	
13a. STATE Maryland			13b. COUNTY Allegany	13c. STREET ADDRESS 11713 Aster Avenue / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Amos - McGraw		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah - York		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -	
17. INFORMANT Wesley A. McGraw, Jr.		18. SOCIAL SECURITY NO. 214-07-6879		19. ADDRESS 206 Forest Drive Cumberland, Md.	

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CHF

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Jaundice L. Org.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24/85 to 8/24/85, that (I) (we) last saw the deceased alive on 8/24/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE P. HAZ MOS		22c. ADDRESS 303 Schlegel St. Cumberland		22d. DATE SIGNED 8/25/85	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/27/85	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park, Cumberland-Allegany-Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.		25. DATE OF REGISTRATION 8/25/85	
202 Greene Street-Cumberland, Maryland 21502		REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2401255

242033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BURDOCK FUNERAL HOME				STATE OF MARYLAND			
1 - STATE REGISTRAR P.O. BOX 523 KITZMILLER, MD.				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH MONTH DAY YEAR			
AUDREY FAY MCROBIE				AUGUST 20, 1985			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
female		white		12 MONTH 16 DAY 1932 YEAR		52 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Garrett		U.S.A.				ALLEGANY COUNTY MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Housewife			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b STREET ADDRESS / ZIP CODE			
Md. Garrett Mt. Lake Pk				Bx. 121 Mt. Lake Pk. 21550			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME					
Dorsey C. Knox		Viola Mae Townsend					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No		220-32-4602		Jr. McCrobie Bx.121 Mt. Lake, PK. Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchiectasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes, Coronary Artery disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>30 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8/20</u> 19 <u>85</u> to <u>8/20</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>R.G. Schmitt M.D.</u> DEGREE <u>MD</u>				22c DATE SIGNED <u>8/21/85</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD G. SCHMITT, M.D.				22e ADDRESS CUMBERLAND, MD, 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		9 23 1985		Garrett Mem. Gar.		Oakland Garrett Md.	
24 FUNERAL DIRECTOR David A. Burdock Kitzmiller, Md. 21538				25a DATE REC'D. BY REGISTRAR <u>AUG 28 1985</u>		25b REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>	

345003

RECEIVED  
FBI  
WASHINGTON, D.C.

APR 20 1988

INTERNAL SECURITY

COMMUNICATIONS SECTION

230-33-6603

RE: [illegible]  
[illegible]

1. [illegible]

COMMUNICATIONS SECTION

RECEIVED



253053

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

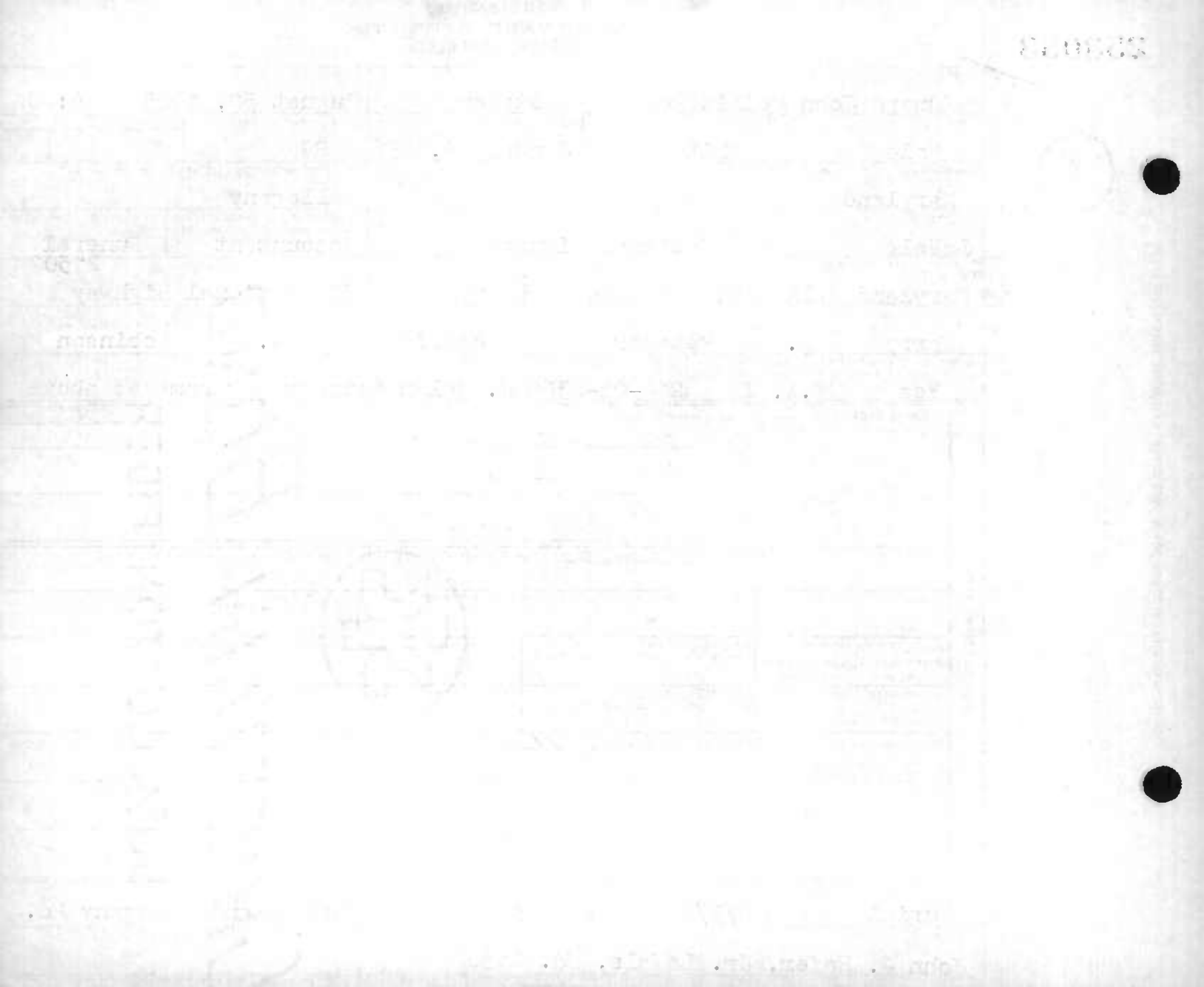
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2130

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward John Wellington Metzger</b>			20. DATE OF DEATH MONTH DAY YEAR <b>August 30, 1985</b>			2b. HOUR <b>4:00A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 4, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>LaVale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>520 National Highway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Funeral</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry E. Metzger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie V. Keller</b>			13e. STREET ADDRESS <b>520 National Highway</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>214-05-6368</b>		17. INFORMANT ADDRESS <b>J. Galen Metzger same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19, 1982</b> , to <b>8/19, 1985</b> , that (I) (we) lost saw the deceased alive on <b>8/10, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. H. Elder</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/30/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. H. ELDER</b>			22e. ADDRESS <b>MEMORIAL MED BLDG</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/3/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>		
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr. LaVale, Md. 21502</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



228023

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 21300

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Josephine NMI Miller			8 5 85			1:55Am		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	9 27 07	77 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
United States	United States		Allegany County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg	Frostburg Community Hospital			Homemaker			Own Home	
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland	Allegany	Frostburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			160 Maple Street, 21532		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
James O. Small			Mary Symons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			213-64-7619			158 Maple St. Eugene Miller, Frostburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Carcinoma Right Breast with DIC. Urinary Tract Infection</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> 19 <u>85</u> to <u>8/5</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>8/4</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. S.J. Sandhir</u>			DEGREE <u>MD</u>			22c. DATE SIGNED <u>8/6/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Dr. S.J. Sandhir			48 Tarn Terrace RXX Frostburg, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Aug. 7, 1985			Frostburg Mem. Park		
23d. LOCATION CITY OR TOWN COUNTY STATE			Frostburg, Allegany, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Durst Funeral Home, Frostburg, Md. 21532			AUG 09 1985 <u>Julia Davidson-Randall</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and fill in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

558033

100% COTTON FIBER  
MADE IN U.S.A.  
DOWN



James  
O. Small  
Mary  
Eugene Miller, President, Md.  
J.S. Harte, Jr.  
System  
Sears, Roebuck & Co.  
Hosiery

James P. Miller, President, Md. 21332  
J.S. Harte, Jr. 21332  
Eugene Miller, President, Md. 21332  
J.S. Harte, Jr. 21332  
System  
Sears, Roebuck & Co.  
Hosiery

235028

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

05 21307

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN RANDALLS MONGOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 12, 1985</b>		2b. HOUR 6:00 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR <b>06-03-1905</b>		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		
12b. KIND OF BUSINESS OR INDUSTRY Maintenance		City of Cumberland				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland						
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 915 Glenwood Street/21502				
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Mongold			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Radcliff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-9141		17. INFORMANT ADDRESS Mrs. Marie Mongold, Cumberland, MD - wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Ischemic Heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
MEDICAL CERTIFICATION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/18/85</b> to <b>8/12/85</b> , that (we) lost saw the deceased alive on <b>8/12/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Shawn A. Nathan</b>		DEGREE		22c. DATE SIGNED <b>8/13/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nathan		22e. ADDRESS 500 Memorial Ave. Memorial Med. Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-15-1985		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				
25a. DATE REC'D. BY REGISTRAR AUG 15 1985		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEF OF BUREAU

200% COPIES

BE

DOING

240148

1- FOR  
STATE  
REGISTRAR

ROTRUCK FUNERAL HOME

85 S. MAIN STREET

KEYSER, WV 26726

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21308

1. DECEASED NAME (TYPE OR PRINT)		MABEL VIRGINIA MOYER		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
				08 14 85		2:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Aug 12, 1911		74	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		U.S.A.				ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Homemaker		-	
13a. STATE				13b. COUNTY			
W. Va.				Mineral			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Piedmont				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE				13f. STREET ADDRESS / ZIP CODE			
Rt 4 Keyser				(E. Hampshire Ext.) 26750			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Guy S. North				Ora - Barrick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
No				216059615			
17. INFORMANT				ADDRESS			
Thomas F. Moyer				Rt 4 Keyser, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left CVA. - severe stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Metastatic renal cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>degenerative atherosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-23-1985</u> to <u>8-14-1985</u> , that (I) (we) last saw the deceased alive on <u>8-14-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>John Mehan</u>		M.D.				8-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOHN MEHANNA, M.D.		909-B SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		17 Aug 85		Potomac Mem. Gardens		Keyser Mineral W.VA.	
24. FUNERAL DIRECTOR NAME				24b. DATE REC'D. BY REGISTRAR			
Allen Rotruck Keyser, W. VA.				AUG 21 1985			
24c. REGISTRAR'S SIGNATURE							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



21602612 Thomas A. Bryant, Jr. 10

ALLAN ROBINSON, M. A.

228041

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

August 4, 1985 12:33<sup>M</sup>1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST

MURNIE

MOYERS

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH 8 DAY 10 YEAR 1928

6. AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

WVa

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD

10. CITY OR TOWN OF DEATH

Cumberland,

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Memorial Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR  
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

WVa

13b. COUNTY

Grant

13c. CITY OR TOWN

Cabins

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

P.O. Box 222

98999  
2685514. FATHER'S NAME  
FIRST MIDDLE LAST

Arlie

Oscar

Reed

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST

Iva

Reel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

215-20-6174

17. INFORMANT

ADDRESS

Bernadine Moyers Cabins, WV 26855

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

GASTROINTESTINAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(c)

CHRONIC LIVER DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

RENAL INSUFFICIENCY

RESPIRATORY INSUFF.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from LEFAY, 19 85, to 4 AUG, 19 85, that (I) (we) last  
saw the deceased alive on 4 AUG, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

William W. Mark, Jr.

DEGREE

ATTENDING  
PHYSICIANMEDICAL  
DIRECTOR ☒STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

5 AUG 85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. William W. Mark

22e. ADDRESS

925 Bishop Walsh Road, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

8-6-85

23c. NAME OF CEMETERY OR CREMATORY

Reel Family Cemetery

23d. LOCATION

CITY OR TOWN

Cabins,

COUNTY

Grant

STATE

WVa

24. FUNERAL DIRECTOR

Blaine Schaffer, Box 155 Petreburg, VA

ADDRESS

25a. DATE REC'D. BY REGISTRAR

AUG 09 1985

25b. REGISTRAR'S SIGNATURE

Julia Davidson



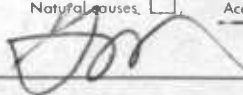

234058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 1 3 1 0 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Bonnie Jean Noland</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8/ 12/ 85</b>		2b. HOUR <b>10:42</b> A M		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04-23-1954</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8/ 12/ 85</b>		2d. HOUR <b>10:42</b> A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Beautician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Salon</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Oldtown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2 Box 72 21555</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Abe</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vertis Santymire</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>216-66-0547</b>		17. INFORMANT ADDRESS <b>Mr. Donald C. Noland, Jr., Oldtown, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8120 IMMEDIATE CAUSE (a) Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:00xx 8/ 12/ 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject driver of auto/truck impact</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 51, Oldtown, Allegany Co., Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>8/12/85</b>		M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>						ADDRESS <b>111 Penn St.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>08-15-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Paw Paw Morgan WV</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1985</b>		25b. REGISTRAR'S SIGNATURE 			

1981

1982

1983



228136

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21311

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian Pearl Owens</b>			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 8 11 85			2b. HOUR 0200				
3. SEX <b>Female</b>	4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH DAY YEAR 7 30 98	6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 11 85			7d. HOUR 0320	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>12502C McMullen Hwy</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>12502C McMullen Hwy / 21502</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Grindle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linda Green</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-28-2951</b>			17. INFORMANT ADDRESS <b>J. William Owens - LaVale, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Chronic congestive heart failure (b) <b>Hypertensive cardiovascular heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Compression fracture L 1 11/84</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Paul Snow</i>			M.D. <b>Paul Snow, M.D.</b>			MEDICAL EXAMINER <b>Memorial Hospital</b>			DATE SIGNED <b>8-11-85</b>	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Ceme.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westernport, Alleg., MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>William G. Kight Cumberland, MD</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1985</b>					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 7 AND 8 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (1))

Charles	Grindle	Linda	Green	\21502	Cumberland	USA	x	Cumberland	Housewife	Own Home
No	J. William Owens - LaVale, MD									

William G. Right Cumberland, MD  
Burial Aug. 14, 1982 Philo Ceme.  
Westernport, Md., MD



238006

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

21312

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn M. Ostley</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>August 12 1985</i>		2b. HOUR <i>1:40 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10/02/94</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cumberland</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cumberland Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>In Own Home</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>	13b. COUNTY <i>Allegany</i>	13c. CITY OR TOWN <i>La Vale</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>514 B Street</i> <i>21502</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Fundenburg</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Laura Keyser</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>249-21-6115</i>	17. INFORMANT ADDRESS <i>Mrs. Dorothy Emerson, La Vale, Md. Niece</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> to <i>8/12</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/12/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. HAZMOs</i>	22e. ADDRESS <i>302 Schley St. Cumberland, Md.</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>8-13-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Funeral Chapel</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Martinsburg, W. Va.</i>
24. FUNERAL DIRECTOR NAME <i>James F. Scarpelli</i>		25a. DATE REC'D. BY REGISTRAR <i>8/16/85</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



241081

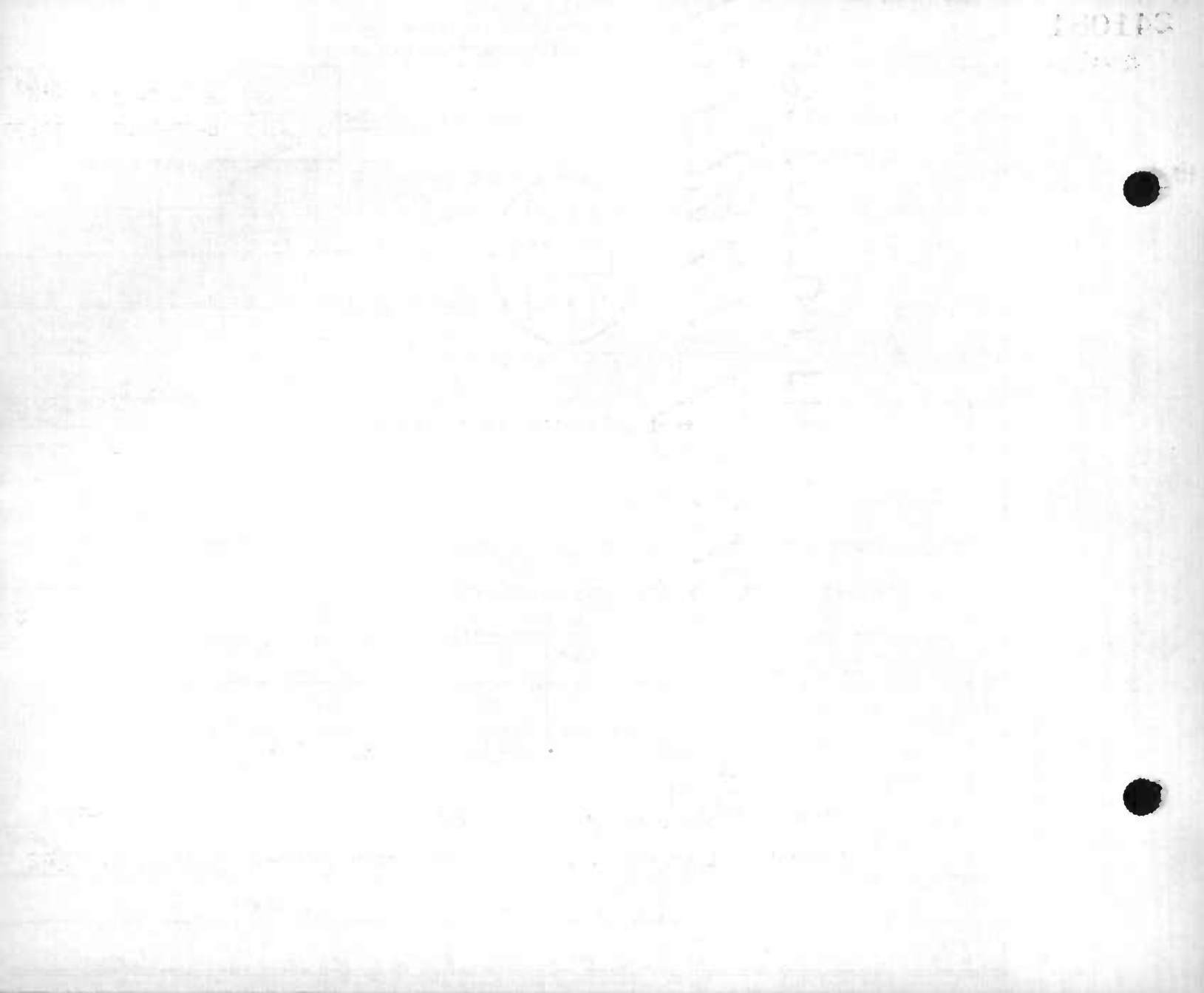
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GRACE PERIODS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>John M. Piper</b>										2a. DATE KNOWN OF DEATH <b>8-20-1985</b>	
3. SEX <b>male</b> 4. RACE <b>white</b> 5. DATE OF BIRTH <b>10-19-1901</b> 6. AGE (IN YEARS) <b>83</b> YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.										2b. HOUR <b>5:40</b> AM	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Spring Gap</b>										2c. DATE PRONOUNCED DEAD <b>8-20-1985</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ret. Trackman</b>										2d. HOUR <b>10:30</b> AM	
13a. STATE <b>MD</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Spring Gap</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>n/a</b> <b>21560</b>											
14. FATHER'S NAME <b>Lionel M. Piper</b>										15. MOTHER'S MAIDEN NAME <b>Emma Moreland</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b> 16b. SOCIAL SECURITY NO. <b>705-09-7013</b>										17. INFORMANT ADDRESS <b>Mrs. Marietta V. Piper, Spring Gap, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Atherosclerotic Heart Disease</b> IMMEDIATE CAUSE (a) <b>DUETO, OR AS A CONSEQUENCE OF</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>DUETO, OR AS A CONSEQUENCE OF</b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>8-20-1985</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b> ADDRESS <b>900 Seton Drive-Cumberland, Md. 21522</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>08-23-1985</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oldtown Allegany MD</b>	
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, MD 21502</b>										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	



234018

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE Margaret POHLING			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1985		2b. HOUR 12:00P								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Frederick Street 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Krause			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-01-4232			17. INFORMANT Norma L. Keller		

18. ADDRESS 1518 B Oldtowne Manor		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO OR AS A RESULT OF (b) DUE TO OR AS A RESULT OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. CAUSE OF DEATH (continued) Cardiomyopathy Small Bowel Obstruction ASCA	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 13, 1985, to July 13, 1985, that (I) (we) last saw the deceased alive on July 13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DR. ANTHONY BOLLINO, JR.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY BOLLINO, JR.		22e. ADDRESS 955 Frederick St., Cumberland, Maryland 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/15/85		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. MD	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
26. ADDRESS 230 Baltimore Ave. Cumberland, Maryland AUG 19 1985							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is only injury, or other traumatic event, the medical examiner must be notified at once.

811182



WILLIAM POWELL

254007

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21315

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas John Price</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 27 1985</b>			2b. HOUR <b>8 a.m.</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 30, 1924</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>61 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 27 1985</b>			2d. HOUR <b>11:20</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>			P MD.
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>189 E. Main Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Biologist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Allegany</b>			13c. CITY OR TOWN <b>Frostburg</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry W. Price</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Kirby</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>189 E. Main St., 21532</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>W.W. 2</b>		16b. SOCIAL SECURITY NO. <b>219-14-7327</b>		17. INFORMANT ADDRESS <b>Henry W. Price Jr., College Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b> M.D.					TITLE (SPECIFY) <b>Medical Examiner</b>		DATE SIGNED <b>8-27-85</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo</b>			ADDRESS <b>900 Seton Dr., Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 31, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg, Allegany, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Durst Funeral Home, Frostburg, Md. 21532</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 09 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Gina Davidson</b>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80



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240015

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

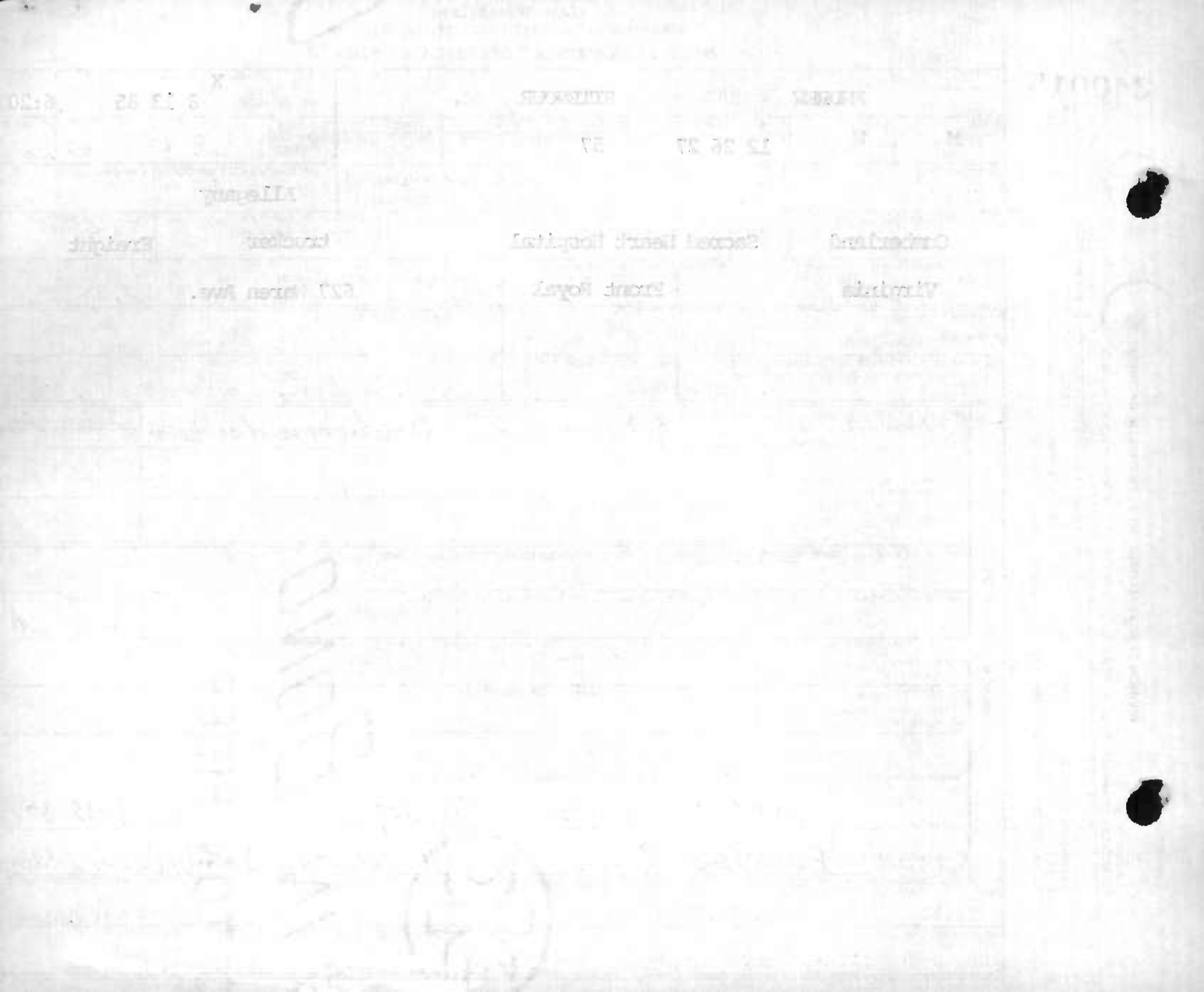
21316

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8 13 85 19 6:20 AM									
1. DECEASED NAME (TYPE OR PRINT) ANDREW JOHNSON RITENOUR, JR.		2b. HOUR									
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 26 27	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8 13 1985 6:20 AM		2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleghany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) trucker		12b. KIND OF BUSINESS OR INDUSTRY Freight			
13a. STATE Virginia		13b. COUNTY Warren		13c. CITY OR TOWN Front Royal		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 627 W. 16th St., Front Royal, Va. 22630			
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Johnson Ritenour, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean (None) Hockman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean Conf.		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Roger L. Ritenour 745 W. 16th St., Front Royal, Va. 22630					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Francisco Reyes		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER			DATE SIGNED 8-13-85				
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes		ADDRESS 900 Soton Dr. Cumberland, Md 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Panorama Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Waterlick, Virginia				
24. FUNERAL DIRECTOR NAME Turner-Robertshaw Fun, Home, Front Royal, Va.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

AUG 21 1985

Julia Davidson-Rendall



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THURSDAY

WEDNESDAY

27

12 26 27

27

Allegany

Franklin

Franklin

Second Street Hospital

Franklin

227 Green Ave.

Franklin

Franklin

227

(227)

234027

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

FREDLOCK FUNERAL HOME				STATE OF MARYLAND			
1- STATE REGISTERED				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
31 JONES STREET PIEDMONT, WV 26757				CERTIFICATE OF DEATH			
REG. NO.				21317			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALLAN LUKE SCHAEFFER				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 14, 1985			
3. SEX Male				2b. HOUR 5:50A M			
4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany			
13c. CITY OR TOWN Westernport				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Rollin Schaeffer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes V. Welsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN 11 216-09-1885			
17. INFORMANT John A. Schaeffer				ADDRESS 404 Maryland Ave. Westernport, Md. 21562			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac, Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon metastatic liver, lung</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Deep dehydration, cellulitis, anemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1985</u> to <u>August 14, 1985</u> , that (I) (we) lost saw the deceased alive on <u>August 14, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Shin Kim</u>				22c. DATE SIGNED 8-14-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHIN KIM, M.D.				22e. ADDRESS 90 MAIN STREET, WESTERNPORT, MD 21562			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 17, 1985			
23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Westernport, Alleg., Maryland			
24. FUNERAL DIRECTOR NAME Fredlock Funeral Home, Piedmont, W. Va. 26750				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 19 1985 <u>Davidson-Rendall</u>			

750152

248016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

GEORGE UPCHURCH FUNERAL HOME STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				21318	
1- FOR REGISTRAR 202 GREENE STREET CUMBERLAND, MD 21502				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NORBERT ANDREW SELLI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>08 21 85</b>		2b. HOUR <b>2:30P M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 13 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food Wholesale</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Sell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret J. Werner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-05-7256</b>		17. INFORMANT ADDRESS <b>Jane Klavuhn 540 Greene St. Cumb., MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>days</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Calculi; Urinary infection</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>8/13 19 85 to 8/21 19 85</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/21 19 85</b> saw the deceased alive on <b>8/21 19 85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. Espina, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/21/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RENATO ESPINA, M.D.</b>		22e. ADDRESS <b>907 SETON DRIVE, CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 30 1985</b>			
24. FUNERAL DIRECTOR NAME <b>George-Upchurch Fun'l. Home, P.A.</b>		24b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>		24c. REGISTRAR'S NAME <b>Jane Davidson-Randall</b>	
24d. FUNERAL HOME <b>Wendy N. Upchurch 202 Greene St. Cumb., MD</b>		24e. REGISTRAR'S NAME <b>Jane Davidson-Randall</b>			

245016

GEORGE HENSON FARMAL HOME  
202 CHERRY STREET  
CHICAGO, ILL. 60601

NOV 21 1952  
CHICAGO, ILL. 60601  
SACRED HEART HOSPITAL



SACRED HEART HOSPITAL

210-05-7028

Donation of

Red Cross

Box of Red Cross

8/15/52

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202 CHERRY STREET, CHICAGO, ILL. 60601



252039

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER JAMES SHAFFER			2a. DATE OF DEATH MONTH DAY YEAR 08 27 85		2b. HOUR 0122 HRS M						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 30 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE IN WORK FORM OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1510 G OLDTOWNE MANNOR 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Shaffer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline Bowser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170 18 2523		17. INFORMANT ADDRESS MEMORIAL HOSPITAL CUMBERLAND MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstr. Pul. Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. Omar Zaman</i>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR OMAR ZAMAN						22e. ADDRESS MEMORIAL AVENUE CUMBERLAND MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08-29-1985		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Somerset Somerset PA				
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR SEP 03 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

220303



UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]

13

227113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

21320

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ESTALINE LULA SHEPPHERD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1985</b>			2b. HOUR <b>6:37</b> PM			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01-19-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>backwining</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>textile</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Allen Eshbaugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine E. Bailey</b>			13e. STREET ADDRESS / ZIP CODE <b>Rt. 9 Box 213 Hinkle Road 21502</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>215-42-4855</b>		17. INFORMANT ADDRESS <b>Mrs. Charlotte L. Deneen, Cumberland, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intubate ca y colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3m</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) this hospital attended the deceased from <u>8-7</u> , 19 <u>85</u> , to <u>8-7</u> , 19 <u>85</u> , that (ii) (we) lost saw the deceased alive on <u>8-7</u> , 19 <u>85</u> , and that (iii) (our) opinion death occurred on the date and hour and from the causes stated above, (li) (we) did not view the body after death.									
22b. SIGNATURE <i>Dr. Bollino</i>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-7-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Bollino</b>						22e. ADDRESS <b>955 Frederick St. Cumberland, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>08-09-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>AUG 12 1985</b>	

335113



228104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie Mabel Shircliff (Schetrompf)			2a DATE OF DEATH MONTH DAY YEAR 08 03 85		2b HOUR 6:00 Pm
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 11-26-1905	6 AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN) COUNTRY PA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10 CITY OR TOWN OF DEATH Cumberland	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress	12b KIND OF BUSINESS OR INDUSTRY Dry Cleaners	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE MD	13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 110 Bedford Street/21502	
14 FATHER'S NAME FIRST MIDDLE LAST Jacob Schetrompf			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally (nmn)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 217-18-4107	17 INFORMANT ADDRESS Raymond E. Shircliff, Jr.-Winchester, VA-son		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute septicemia. DUE TO, OR AS A CONSEQUENCE OF (b) Infected Richard's nail. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
O.C.A.D with C.H.F. (2) Old C.V.A & Rt. sided Paresis

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9-28, 1983, to 8-3, 1985, that (I) (we) last saw the deceased alive on 7-29, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE V.A. Ranjithan		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 8-5-85
22d PHYSICIAN'S NAME (TYPE OR PRINT) Vimala Ranjithan		22e ADDRESS Memorial Medical Bldg., Cumberland, Md. 21502	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 08-07-1985	23c NAME OF CEMETERY OR CREMATORY Buck Valley Mem. Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Buck Valley PA
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24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502	25a DATE REC'D. BY REGISTRAR AUG 08 1985	25b REGISTRAR'S SIGNATURE Julia Davidson-Rendell
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AUG 30 1985



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226030

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

2

1

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2

3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LEILA Brady SUTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 5, 1985</b>		2b. HOUR <b>3:13A.</b> M		
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 7, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Brady</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Travis</b>		13e. STREET ADDRESS / ZIP CODE <b>20 West College Avenue 21532</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-58-6617</b>		17. INFORMANT ADDRESS <b>John I. Rogers, 11 Keyser, W. Va. 26726</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. QAMAR ZAMAN</b>		22e. HOSPITAL <b>MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 7, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westernport, Alleg. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Eredlock Funeral Home,</b>		ADDRESS <b>Piedmont, W. Va.</b>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>AUG 12 1985</b> <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

226030



New York

U.S.A.

Dec. 7, 1962

Allegany

Teacher

Public School

Eastwing

John

John

Travis

130 North Main Street

John T. Rogers, Jr., Kansas, U.S.A. 66102



100% COTTON FIBER

POWER

Booked

Jan. 7, 1963

Allegany County

Westonport, Allegany, Maryland

Franklin County, West Virginia

228112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 only should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who certifies death must be notified at once.

SCARPELLI FUNERAL HOME

1- FOR STATE RECORD  
108 VIRGINIA AVENUE  
CUMBERLAND, MD 21502STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA EDNA SWICK			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 4, 1985		2b. HOUR 16:30 M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01-24-1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY own home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 32 Humbird Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Walter J. Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mahala Fazenbaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 214-16-2302		17. INFORMANT ADDRESS Mr. John W. Swick, Cumberland, MD -husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrene left leg, Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Diabetes mellitus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/4</i> 19 <i>85</i> to <i>8/4</i> 19 <i>85</i> that (I) (we) last view the deceased alive on <i>8/4</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)					
22b. SIGNATURE <i>Richard H. Snider, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/5/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SNIDER, M.D.		22e. ADDRESS PO BOX 2455, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 08-07-1985	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR AUG 08 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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WINTERHARD  
120% COLTON

COMMUNITY FURNACE HOME  
100 VIRGINIA AVENUE  
CHATELAIN, VT 05202

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SWICK  
AUGUST 11, 1982  
10:30

SACRED HEART HOSPITAL

214-16-2205

ALLEGANY COUNTY

RICHARD SWIDER, M.D.  
PO BOX 2022, CHATELAIN, VT 05202

253015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ELIZABETH LAST THOMAS			2a DATE OF DEATH MONTH DAY YEAR August 27, 1985		2b HOUR 4:45 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 14, 1909		
6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home		13a STATE Penna.		
13b COUNTY Somerset		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST John Rodamer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Thomas		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) NO ---		
16b SOCIAL SECURITY NO. 160-12-3652		17 INFORMANT ADDRESS Rt. 1, Box 353 A.L. Thomas, Salisbury, PA 15558		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholangiocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION CITY OR TOWN COUNTY STATE		22a I certify that (u) (this hospital) attended the deceased from <u>July</u> , 19 <u>85</u> , to <u>27 Aug</u> , 19 <u>85</u> , that (u) (we) lost saw the deceased alive on <u>26 Aug</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (u) (we) (did) (do not) view the body after death.		22b SIGNATURE DEGREE <u>Dr. F. W. Miltenberger M.D.</u> 22c DATE SIGNED <u>27 Aug 85</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. F. W. Miltenberger		22e ADDRESS 122 S. Centre Street Cumberland, MD 21502		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
23b DATE 8-29-85		23c NAME OF CEMETERY OR CREMATORY Salisbury Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Somerset, PA		
24 FUNERAL DIRECTOR <u>Dr. J. J. Devore</u>		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
ADDRESS Grantsville, MD						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





239003

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21326

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Elizabeth Tichnell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 15 1985</b>			2b. HOUR M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 3 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Barton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box 83 Barton, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>House</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Barton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Nelson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ollie Riggleman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>212-18-1738</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Kyle Barton, Md. 21521</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma of the breast</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>coronary artery disease; chronic obstructive pulmonary disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN F. SCHUBERTZ, M.D.</b>			22e. ADDRESS <b>FROSTBURG PLAZA, FROSTBURG, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/17/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Lawn Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale Allegany Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Boals Funeral Service</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
ADDRESS <b>Westernport, Md. 21562</b>										

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21327

1. DECEASED NAME (TYPE OR PRINT) <b>Grace NMN Trevaskis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 22 85</b>		2b. HOUR <b>4:50 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4/12/84</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>101</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>220 Baltimore Ave. 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Curnow</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann Thomas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-52-9434</b>		17. INFORMANT <b>Ruth Wanda, daughter Cumberland, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CAD.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Partial ileus.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P. HALMOS</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/23/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. HALMOS</b>		22e. ADDRESS <b>302 Schley St. Cumberland,</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/24/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Alleg. MD</b>
24. FUNERAL DIRECTOR NAME <b>Leasure-Stein Funeral Home</b>		24b. ADDRESS <b>230 Baltimore Ave. Cumberland, MD 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1985</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate. Pages 1, 2, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HUBBARD VERNON TWIGG			2a DATE OF DEATH MONTH DAY YEAR AUG 26 1985		2b HOUR 9:40AM M				
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 04 24 1909		6 AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD			
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT PLACED IN CITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b KIND OF BUSINESS OR INDUSTRY railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD		13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 343 Dorn Avenue/21502	
14 FATHER'S NAME FIRST MIDDLE LAST Robert R. Twigg					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ann Keefer				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705 05 9221		17 INFORMANT ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE CUMBERLAND MD 21502					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Serious Coronary Artery disease + COPD</u>									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from <u>8/5/85</u> to <u>8/25/85</u> , that (I) (most) saw the deceased alive on <u>8/25/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Shan A Nathan</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/27/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR, SHAN A NATHAN		22e. ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-29-1985		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR SEP 03 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Pondell</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES

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FOR THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [illegible]



RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

TO: [illegible]

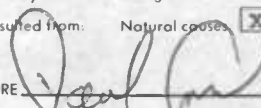
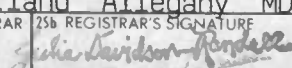
FROM: [illegible]

246083

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFERMENT. PAGES 1-AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))
1- FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
21329  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James Edward Valentine</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-26 1985 DEAD <input type="checkbox"/> 8-26 1985			2b. HOUR 10A		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-25-1919</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>65</b> YRS.	IF UNDER 1 YR. MONTHS DAYS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Aug. 26</b> 1985	7d. HOUR <b>7:45</b> p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>501 Eastern Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BD of Education</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Valentine</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Anne Wrightson</b>		13e. STREET ADDRESS <b>501 Eastern Ave. 21502</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Mr. William L. Valentine, Cumberland, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Gout; Obesity</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>8-26-1985</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Paul Snow MD</b>		ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>08-29-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, MD 21502</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1985</b>		25b. REGISTRAR'S SIGNATURE 		



240023

ONE  
EX-111  
11

NOT CO. NOE

Very faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "NOT CO. NOE" are visible.

228083

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE (TERESA) WAGNER				2a. DATE OF DEATH MONTH DAY YEAR Aug. 3, 1985		2b. HOUR 10:22 <sup>a</sup>	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 10-04-1901		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria worker		12b. KIND OF BUSINESS OR INDUSTRY school	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Agustus Lange				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Shoemaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-6110		17 INFORMANT ADDRESS Mr. William F. Wagner, Cumberland, MD -son			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>6 DAYS.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William Lamm</u>				DEGREE MD		22c. DATE SIGNED 8-5-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Lamm, M.D.				22e. ADDRESS Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-06-1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE RECD. BY REGISTRAR 8-5-85 REGISTRAR'S SIGNATURE <u>J. Davidson-Rodgers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON LIME

100% COTTON LIME



PAGE 2

100% COTTON LIME

7-2-2

100% COTTON LIME

100% COTTON LIME

242126

-STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 21331

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edna Marie Ward			2a. DATE OF DEATH MONTH DAY YEAR 8 15 85			2b. HOUR 2:47 P.M.				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 6 96		6 AGE (IN YEARS LAST BIRTHDAY) 38 88 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.				
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CONRAD STEELE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH WILLIAMS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A. 212-01-9655	
17. INFORMANT ADDRESS MRS. DORIS PRESSMAN, 31 MT. PLEASANT ST			18. STREET ADDRESS / ZIP CODE 31 Mt. Pleasant Street 21532			19. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE NAME AND ADDRESS BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Allegany Frostburg			20. DATE OF OPERATION	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pericardial edema, CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiac arrhythmia, post myo-</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <u>cardiac infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 7</u> , 19 <u>85</u> , to <u>Aug. 15</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Aug. 15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above, if included) (did not view the body after death).							
22b. SIGNATURE <u>Shin E. Kim</u>				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shin E. Kim, M.D.				22e. ADDRESS Main Street Westernport, MD 21562		22f. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/18/85		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD	
24. FUNERAL DIRECTOR <u>Michael M. Sowers</u> SOWERS FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified on page 4.

18

RECEIVED  
FBI  
JAN 11 1964

17  
21832

COMMAD

STATION

1 BY

ELIZABETH

PROTESTING TO

DR. J. J. PHARMAN, 31 MT. PLEASANT ST.



COTTON FIBER

RECEIVED  
FBI  
JAN 11 1964  
COMMAD  
STATION  
1 BY  
ELIZABETH  
PROTESTING TO  
DR. J. J. PHARMAN, 31 MT. PLEASANT ST.

234044

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. WASHINGTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 77  
DHWA - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						21332	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
<b>1- FOR STATE REGISTRAR</b>							
<b>2a. DATE KNOWN OF DEATH</b>		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	<b>2b. HOUR</b>		
ESTIMATED <input type="checkbox"/>		8	15	1985	M		
<b>3. SEX</b>		<b>4. RACE</b>		<b>5. DATE OF BIRTH</b>		<b>6. AGE (IN YEARS)</b>	
Female		Colored		July 25, 1962		23 YRS.	
<b>BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b>		<b>7b. CITIZEN OF WHAT COUNTRY?</b>		<b>8. MARRIED</b>		<b>9. BALTIMORE CITY OR COUNTY OF DEATH</b>	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany County, MD	
<b>10. CITY OR TOWN OF DEATH</b>		<b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b>		<b>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</b>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b>	
Cumberland		Sacred Heart Hospital		Cashier		Restaurant	
<b>13a. STATE</b>		<b>13c. CITY OR TOWN</b>		<b>13d. INSIDE CITY LIMITS?</b>		<b>13e. STREET ADDRESS</b>	
W.Va.		Mineral		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		47 Erin Street, 26750	
<b>14. FATHER'S NAME</b>		<b>15. MOTHER'S MAIDEN NAME</b>					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Clarence T. Washington		Mildred Yvonne Phillips					
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)</b>		<b>16b. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b>			
NO		236-11-8813		Mildred V. Washington same as 13			
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:</b>							<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>
8120 IMMEDIATE CAUSE (a) Multiple injuries							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>				<b>20. AUTOPSY?</b>	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b>		<b>21b. TIME OF INJURY</b>		<b>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)</b>			
		HOUR AM MONTH DAY YEAR		Driver in auto/tractor trailer impact			
10:40 M. 8 15 1985							
<b>21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/></b>		<b>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)</b>		<b>21f. LOCATION</b>			
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		road		U.S. Rt. 220 s. of Rawling, Allegany, MD.			
<b>22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b>		<b>TITLE (SPECIFY)</b>		<b>M.D.</b>		<b>DATE SIGNED</b>	
Margaret Ann Shell		Assistant				8/16/85	
<b>EXAMINER'S NAME (TYPE OR PRINT)</b>		<b>ADDRESS</b>					
Margarita A. Korell, M.D.		111 Penn St. Balto.MD.					
<b>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>23b. DATE</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b>	
Burial		8-19-85		Potomac Mem. Gardens		Keyser, Mineral, W. Va.	
<b>24. FUNERAL DIRECTOR NAME</b>		<b>ADDRESS</b>		<b>25a. DATE REC'D. BY REGISTRAR</b>		<b>25b. REGISTRAR SIGNATURE</b>	
Fredlock Funeral Home,		Piedmont, W.Va. 26750		AUG 20 1985			

631011

United States

Post Office

July 27, 1942

U.S.A.

Washington

Post Office

47 East Street, 20750

Post Office

Post Office

U.S.A.

Washington

Post Office

200-1-1012

NO

Washington, D.C. 20750

100-1-1012

100-1-1012

Post Office, Washington, D.C. 20750

Post Office, Washington, D.C. 20750



228075

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DURST FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
FROSTBURG, MD 21532				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
MARGARET L WHETSTONE				AUGUST 5, 1985			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Female		White		MONTH DAY YEAR		YRS	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Presser		Pajama Co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Allegany		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Rt. 1, Box 275, 21532			
Ralph B. Skelley		Lula M. Lease					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
(YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		Judy Crissinger, Same as 13e			
No		213-24-5126					
18. CAUSE OF DEATH							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Refractory Congestive Heart Failure							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Coronary Artery Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
Auto Heart Failure - Necrotizing Cellulitis Right Leg							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE			
AT WORK <input type="checkbox"/>							
22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (i) (we) lost							
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
above, (i) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
KENNETH ZEINKIEWICZ, MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 8 '85		Frostburg Mem. Park		Frostburg, Allegany, STATE, Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS				AUG 09 1985		Judy Crissinger	
Durst Funeral Home, Frostburg, Md.							

BP

228075

WITTH

WEST BUREAU  
HAWKINS  
PROSTATE, MD 21231

HAWKINS

1

WESTSTONE

AUGUST 8, 1982

11:22 A

ALLEGANY COUNTY

SACRED HEART HOSPITAL

11:22 A

11:22 A

11:22 A

202 FIFTH AVENUE DRIVE, QUANTICO, MD 21202

KENNETH THOMPSON, MD

11:22 A

11:22 A

248129

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21334

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE JANE WIEGAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 28, 1985</b>			2b. HOUR MIN. A. M. <b>5:55 A. M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 26, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>72</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. <b>72</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Amcelle Celanese</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Corporation</b>	

13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>LaVale</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>23 Harold Street / 21502</b>		
-------------------------------	--	--	--------------------------------	--	--	------------------------------------	--	--	---	--	--	---	--	--

14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Eckard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Dale Hawkins</b>		
--	--	--	---	--	--

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-03-8087</b>		17. INFORMANT ADDRESS <b>William Wiegand 11090 Lighthouse Dr. Belleville, Michigan</b>	
---	--	---	--	--	--

18. CAUSE OF DEATH (Enter only one cause per location, (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Hypertension COPD**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	--	--	--	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
--	--	--	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
---	--	--	--	---	--

22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/85</b> to <b>8/28/85</b> , that (I) (we) last saw the deceased alive on <b>8/28/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
--	--	--	--	--	--

22b. SIGNATURE <b>Dr. Nathan</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/30/85</b>	
-------------------------------------	--	--------	--	--	--	------------------------------------	--

22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NATHAN</b>		MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
--	--	--	--	--	--	--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-31-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland-Allegany Co.-MD.</b>	
--	--	-----------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR NAME ADDRESS <b>George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Gene Davidson-Randall</b>	
---	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

219

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10% COLONY LIBRARY



248026

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21335

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Wright Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 20 85</b>			2b. HOUR <b>7<sup>55</sup> PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 10 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Textiles</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Celanese</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20 Campground Rd. 21502</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David D. Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jemima Wright</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>220-10-8691</b>		17. INFORMANT ADDRESS <b>Helen E. Bosley LaVale, Md. 20 Campground Rd.</b>					

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **COPD with Emphysema, CBS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CVA - Cong. Hemiplegia, chronic**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 15 1985</b> to <b>Aug 20 1985</b> , that (I) (we) last saw the deceased alive on <b>Aug 20 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) did not view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/23/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fbg. Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fbg. Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home</b>				57 Frost Ave. <b>Frostburg 21532</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO THE HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.  
FROM THE  
COMMISSIONER OF THE  
BUREAU OF REVENUE  
DEPARTMENT OF THE TREASURY

RECEIVED  
JAN 10 1911  
U. S. DEPT. OF THE TREASURY  
BUREAU OF REVENUE  
WASHINGTON, D. C.



*[Faint, illegible handwritten text and signatures]*

228036

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

21330

1 DECEASED NAME (TYPE OR PRINT) Steven J Winter			2a DATE OF DEATH MONTH DAY YEAR 8/04/85			2b HOUR M A					
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 5/ 18/ 09		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany Co MD					
10 CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Invalid			12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a STATE Maryland			13b COUNTY Allegany		13c CITY OR TOWN Midlothian		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Legislative Road, 21543		
14 FATHER'S NAME FIRST MIDDLE LAST James Winter			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Mc Mahon			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b SOCIAL SECURITY NO. 220 16 7008			17 INFORMANT ADDRESS 524 A St. Mrs. Linda Buckel, La Vale, Md. 2102								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>Aug 3</u> , 19 <u>85</u> , to <u>Aug 4</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Aug 4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.											
22b SIGNATURE <u>Charles E. Oh</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>8/6/85</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Oh						22e ADDRESS 48 Tarn Terrace, Frostburg, Md 21532					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Aug. 6, 1985		23c NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Allegany, Md			
24 FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md. 21532						25 RECORD BY NAME John S. ...					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical certificate must be notified at once.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



Don't you?

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6. Level 2

EVIDENCE

Widom

YINDELIA

9. 0. 0. 0.

Figure 2



200

On

Mr. Lindholm, in a letter dated 11/15/54, advised that the above information was obtained from the files of the Federal Bureau of Investigation.

228035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										21337 REG. NO.	
1- FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Francis A. Yenshaw</b>						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 4 1985</b>		2b. HOUR <b>0225</b>			
3. SEX <b>Male</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 4, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>64 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 4 1985</b>		7d. HOUR <b>0225</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>48 Linden Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Invalid</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Allegany</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>48 Linden St., 21532</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Yenshaw</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Althea Beach</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-10-6663</b>		17. INFORMANT ADDRESS <b>Mrs. Nellie Beach, Frostburg, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma pancreas, primary</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Paul Snow</i>				TITLE (SPECIFY) M.D. <b>Ast. Dpty</b> MEDICAL EXAMINER				DATE SIGNED <b>8-4-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow, M.D.</b>				ADDRESS <b>Memorial HOsptial</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 6, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Durst Funeral Home, Frostburg, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 09 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Daniel David M Yommer			2a. DATE OF DEATH MONTH DAY YEAR 8/9/85			2b. HOUR 5:40a M							
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/24/88 1884		6. AGE (IN YEARS LAST BIRTHDAY) 22 100 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 74 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleg. Co. MD.							
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watchman		12b. KIND OF BUSINESS OR INDUSTRY Saw Mill					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Route 21536					
14. FATHER'S NAME FIRST MIDDLE LAST George Yommer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Witzgall							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---				16b. SOCIAL SECURITY NO. 159 12 2274		17. INFORMANT Route 2, Box 19 Clemon Yommer, Grantsville, MD 21536							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATELECTASIS OF LEFT LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>TUMOR OBSTRUCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ARTERIOSCLEROTIC HEART DISEASE</u>													
19a. DATE OF OPERATION 3		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> , 19 <u>85</u> , to <u>August 9</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>August 8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>S. Chang M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/9/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang						22e. ADDRESS Frostburg, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-85		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, MD							
24. FUNERAL DIRECTOR NAME Newman						ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR AUG 14 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove confidential information. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HATTIE ANA ZIES			2a. DATE OF DEATH MONTH DAY YEAR August 18, 1985			2b. HOUR 2:50 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WV 13b. COUNTY Hampshire 13c. CITY OR TOWN Greenspring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural 26722		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Wesley Parlett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Elizabeth Burton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-96-9378		17. INFORMANT ADDRESS Daphne Davis, Rt. 1, Box 62, Old Town, Md. 21555					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>TERMINAL STAGE of HUNTINGTON'S CHOREA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MALNUTRITION</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NA</u>									
19a. DATE OF OPERATION <u>NA</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>NA</u> 19 <u>85</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>NA</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>NA</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>NA</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-1-</u> , 19 <u>85</u> , to <u>8-17-</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8-17-</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mohammad Shafiei</u>					DEGREE M.D.			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mohammad Shafiei					22e. ADDRESS 915 Seton Drive Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/1985		23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenspring Hampshire WV			
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Romney, West Virginia					25a. DATE REC'D. BY REGISTRAR AUG 23 1985		25b. REGISTRAR'S SIGNATURE <u>John R. Riddle</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the detached page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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